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ITALIAN HEALTH CARE REFORM

BY LIVIO GARATTINI

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Livio Garattini

January 1992

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ACKNOWLEDGEMENTS

The author would like to thank Martin McKee, Senior Lecturer of London School of Hygiene and Tropical Medicine, for his very helpful correction of the manuscript (when it was still written in "spaghetti" English!); John Abel Smith, Professor of London School of Economics, and Ray Robinson, Deputy Director of the King's Fund Institute, for their moral support at the start of the work; John Smith and Ritchard Brazil, deputy directors of the King's Fund College, for their great help during the period spent in London; Mark McCarthy, Senior Lecturer of the Department of Community Medicine - University College London, and Fitzroy Ambursley, Fellow of the King's Fund College, for their critical contribution to the paper.

He is also particularly grateful to Sal McNeil of the Centre for Health Economics for her secretarial and administrative support.

"Last but not least", he would like to express his special thanks to Sue Hennessy, who undertook the difficult task of editing this paper.

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FOREWORD

It is remarkable how health care systems, created over decades and influenced by very different cultures, exhibit similar problems. Most health care systems are compartmentalised with managers at margins responding to perverse incentives and seeking to shift patients and costs onto rival organisations. Decision makers behave selfishly, considering the welfare of their own organisations rather than those of the health care system as a whole, and in the absence of evidence about the cost-effectiveness of competing treatments.

Not only are the problems similar across health care systems, their resolution by politicians is also tackled in ways which are common. Thus in Italy the language and reforms of the UK-NHS is affecting policy. The UK management reforms of the mid-1980s are now being translated into Italian innovations which include new contracts and performance related policy. The Italian GP contract has been altered and there is a desire to improve the efficiency of the supply side.

The defects of the Italian health care system and their reform to produce health gains at lower cost are not well informed by evidence and, like the UK reforms, policy often appears to be conceived hastily and poorly evaluated. The lessons to be learnt from this paper are that many of the problems of health care systems with very different structures are common and there are few proven methods of resolving them.

1. THE INSTITUTIONAL FRAMEWORK

1.1 The Reform Act

1.1.1 A New Framework for the NHS

After the Second World War, Italy developed a social insurance system of health care similar to that of other West European countries. There were a number of occupational schemes administered by a variety of autonomous sick funds, the "casse mutue". Under these schemes cash benefits and direct health care were provided through contracts with doctors, hospitals and pharmacies and there was considerable variation in the range of benefits and quality of health care received. The system failed mainly because of financial pressures experienced by the "casse mutue".

In 1978, a National Health Service (NHS) was introduced in Italy following the passing of Reform Law N.833. The 1978 Act was based on the principle that "The Republic will protect health as a fundamental right of the individual and interest of the collectivity through the National Health Service".

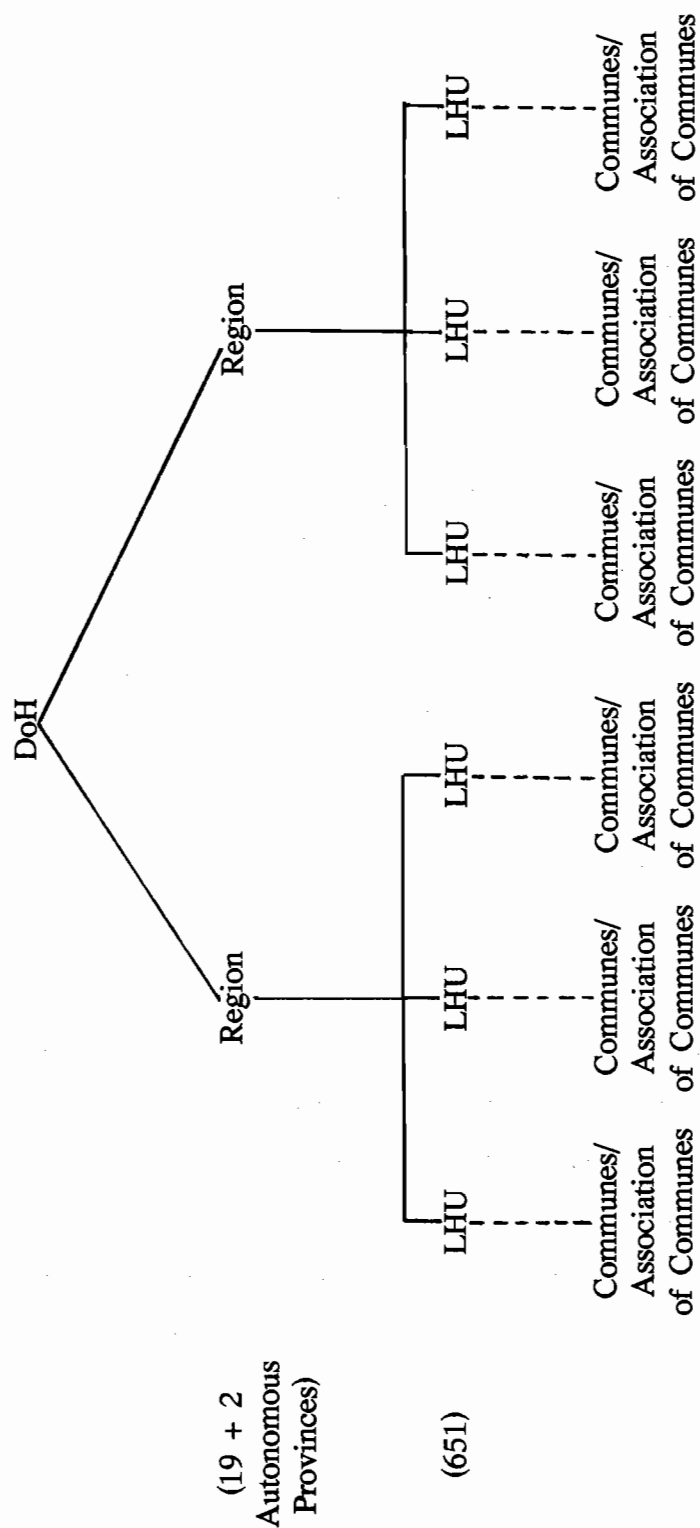
The Law laid down the main goals of the NHS as:

1. the elimination of inequalities in health between different areas of the country;
2. the prevention and treatment of mental illness;
3. the promotion of the health of young people at school, of the elderly and of the handicapped;
4. the safety and therapeutic effectiveness of pharmaceuticals;
5. safety at work;
6. the safety of food and drink, including the prevention of disease among livestock on farms;
7. the identification and the elimination of causes of environmental pollution.

The Reform Law established a new institutional framework for the NHS (Figure 1.1).

Figure 1.1

ORGANISATIONAL FRAMEWORK OF THE ITALIAN NHS



At the national level the system is directed by the **Department of Health** (DoH). The main functions of the DoH are:

- (i) Planning. Comprehensive planning is based on a three year plan, the **National Health Plan (NHP)**, which covers strategic objectives, financial expenditure, training requirements and inter-regional coordination. The (NHP) has to be consistent with national socio-economic plans;
- (ii) Allocation of financial resources among the Regions (see Section 3.2);
- (iii) The stipulation of contracts of NHS personnel and of the private professionals (for example, GPs) and private facilities (for example, hospitals) contracted to work for the NHS (see Section 2);
- (iv) The control of registration, production, testing, trading and information on: drugs, all medical equipment and products with a potential impact on the environment;
- (v) International relations.

Research and development are provided by the **Superior Institute for Occupational Prevention and Safety**, with regard to occupational health, and by the **Superior Health Institute**, the highest technical and scientific advisory body of the NHS (with around 2500 employees), with reference to any other health issues.

Health policy advice is provided by the **National Council of Health**, composed of around 40 representatives mainly appointed by government departments and the Regions. The National Council of Health plays an important role in approving the NHP.

1.1.2 Local Health Service Structure

The second geographical level is represented by the **Regions**, of which there are 20

in Italy¹. The main functions of the regional authorities are:

- (i) Planning. The Regions must produce a plan, known as the **Regional Health Plan** (RHP), which lasts three years and must be consistent with the NHP and other plans for regional development;
- (ii) Definition of the territory of the Local Health Units (see below);
- (iii) Allocation of financial resources among the Local Health Units (using criteria which can be different from those utilized at the central level by the DoH) (see Section 3.2);
- (iv) Coordination and/or integration with Social Services;
- (v) Definition of the organisational structure of the Local Health Units.

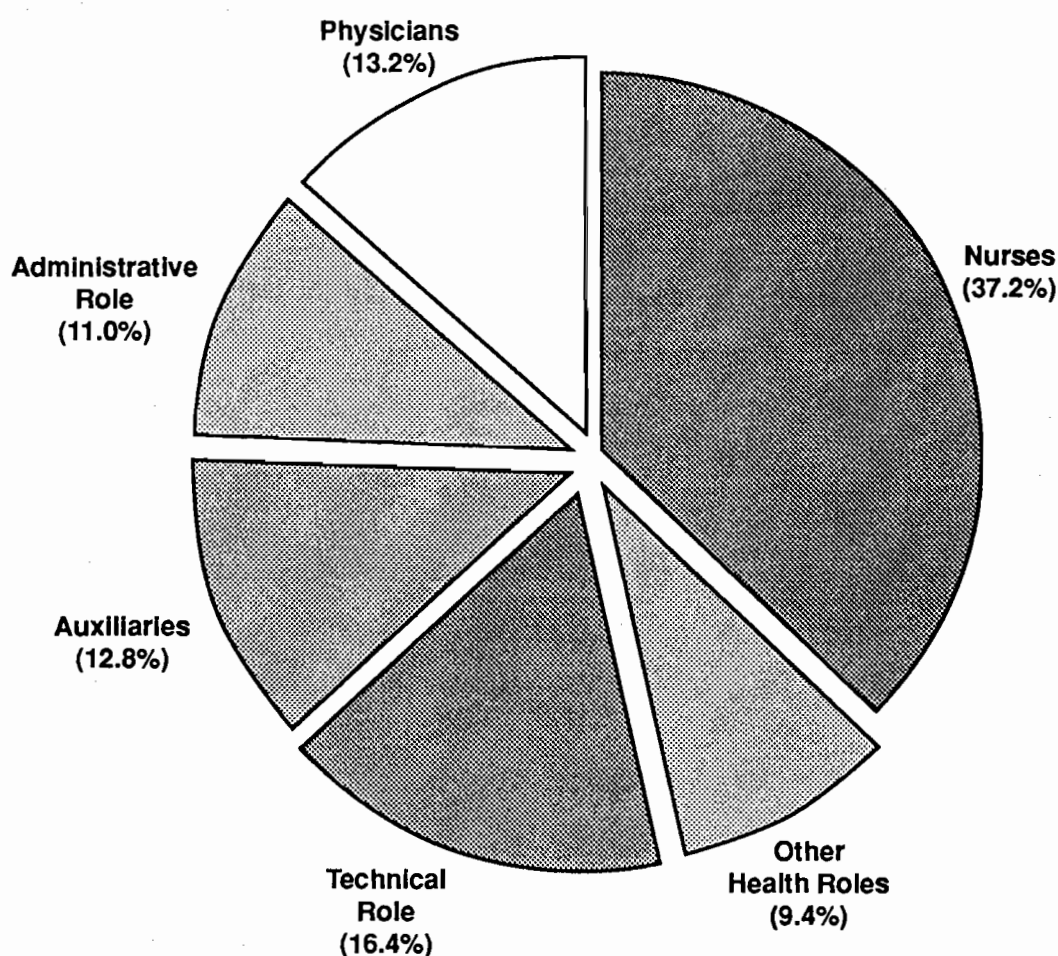
Health services are provided through **Local Health Units** (LHU - in Italian USL)²; their total number is 651.

LHUs comprise "the set of units, offices and services of the communes, which in a certain area perform the duties of the NHS". They have no institutional autonomy, being considered an agency of the Communes³. NHS personnel who work in LHUs were

-
- (1) They could be considered 21, because the two provinces of the region Trentino-Alto Adige are completely autonomous. This autonomy is related to the different language spoken in the two provinces (in the province of Bolzano, annexed to Italy after the First World War, the population speaks German).
 - (2) USL is the most utilized term for this level, but not the only one. Some regions have called them USSL (Local Social Services and Health Units) or ULSS (Social Services and Health Local Units!) because they decided to integrate some social services within the units.
 - (3) Communes in Italy are equivalent to British local authority councils.

estimated to be 623,000 in 1989⁴. Graph 1.1 illustrates the distribution of staff among different occupational groups: physicians account for 13.2% of the total, nurses and midwives 37.2%, technical employees (workers in charge of maintenance and control services, statisticians, sociologists and social workers) 16.4%, and administrative and clerical employees 11%.

GRAPH 1.1
EMPLOYEES OF THE NHS



Source: DoH (Central Service for Health Planning)

(4) This datum does not include self-employed workers of the NHS (for instance General Practitioners). Unfortunately figures about NHS personnel are still not very reliable (for further details see the introduction to Section 2).

The LHU is administered by a **Management Committee**, which is composed of political appointees. The members of the Management Committee are appointed by the **General Assembly** of the LHU, which is composed of the Councillors of the Communes included in the LHU territory⁵. One member of the Management Committee, is designated as **Chairman of the LHU**. The total number of members of the Management Committee can vary, after the law 4/1986, from a minimum of five to a maximum of seven depending on the size of the LHU.

Theoretically members of the Management Committee can be the same politicians as those elected to communes, but in fact this is rarely the case. The Management Committee conducts all the administrative transactions of the LHU.

The top management of the LHU is represented by the **Directing Office**, composed of all of the Directors of the health and administrative services. The Office also comprises **Health and Administrative Coordinators**, whose task is to coordinate service activity.

The way in which the **Services** within the LHU are organised can vary from one Region to another (as noted above). However the health services are inevitably related to the main activities the law requires the LHU to deliver. These include:

- health promotion;
- public health (including environmental health);
- occupational health;
- primary care;
- community care;
- outpatients specialist care;
- hospital care;
- pharmaceutical care;

(5) The territory of a LHU can either include several Communes, or exactly coincide with the territory of one Commune, or be only a part of the territory of one Commune (for example in cities like Rome and Milan).

- veterinary care⁶;
- mental health services;
- social services.

Figure 1.2 gives an example of the structure of a LHU. Finally it is necessary to point out that the LHU is divided into **Districts**. These are functional divisions which are intended to enable better coordination of primary care services (see Section 2.1)⁷.

1.2 The Problems

Although all health care systems face considerable difficulties, the administrative and managerial weaknesses of the Italian system are substantial and extreme. The performance of the Italian NHS in its first ten years, in terms of effectiveness and efficiency, is generally felt to have been unsatisfactory.

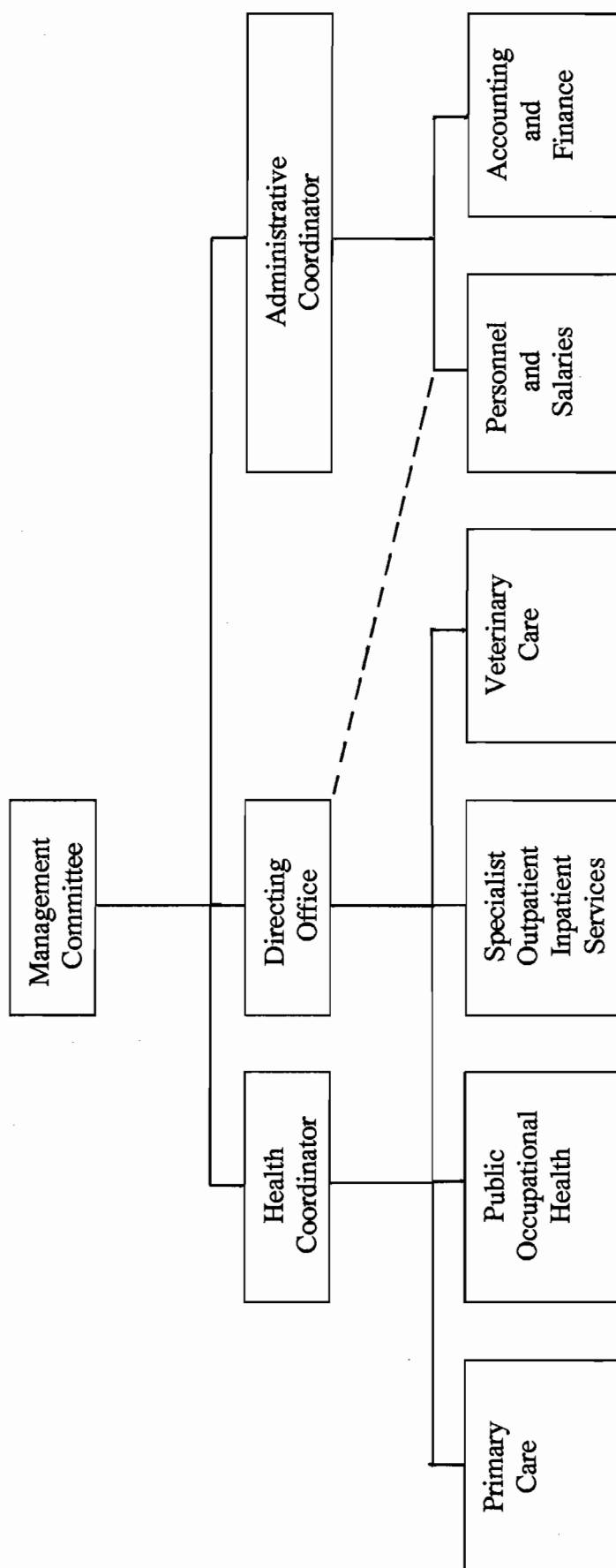
There are many reasons for this situation, some of which are linked to the Italian political system, whilst others result from the internal organisation of the NHS. This section will focus on the problems caused by institutional and organisational factors, whilst those related to service provision and to financial arrangements will be discussed in the following sections.

1.2.1 Structural Problems at National Level

The Italian administrative system is based on three autonomous tiers: State, Regions

-
- (6) Veterinary care includes two main activities: prevention of disease amongst farm livestock; and ensuring the safety of food derived from animals.
 - (7) In practice, the LHU can be considered the equivalent of an English District Health Authority, but Italian districts are not the exact equivalent of English Units as they only deal with primary care and provide different services.

Figure 1.2
EXAMPLE OF THE ORGANISATIONAL STRUCTURE OF A LHU



(20) and Communes (more than 8,000)⁸. This autonomy is recognized by law and every tier has its own elections; in practice this means that the Health Minister in a regional authority is an elected councillor and is appointed by the regional Prime Minister and accountable to him⁹. Consequently, the Italian NHS is affected by the weak hierarchical relationships which exist between the administrators of the political system at different levels.

There are three main results of this weakness:

1. The **existence of continuous disputes among the different levels**, particularly, but not only, about financial resources (see Section 3.2).
2. The **"regionalisation" of the system**, that is, the increasing inequalities among the Regions in terms of effectiveness, efficiency and quality of services delivered¹⁰. This makes it more and more difficult to analyse the Italian NHS as a unique system and calls for frequent explanations about local differences.
3. The **artificial increase of the total number of LHUs** (651), each of them being considered a centre of political power, and their consequent small size in comparison with a rational territorial allocation of health services. Around 30% of

(8) Actually the Italian administrative system has four tiers: between the regions and the communes there are the provinces (95 in all). Nevertheless provinces have not been mentioned in the text because their importance has markedly lessened (apart from the two autonomous provinces noted in footnote (1)) after the introduction of regions in the 1970s; in particular they have no role in the NHS (all their responsibilities at present are limited to road maintenance and development planning). However the Law 142/90 which reforms the role of territorial authorities assigns them some functions in relation to environmental health.

(9) In the example provided the literal translation from Italian has deliberately not been used, so as not to generate confusion. The actual title of the Health Minister at the regional (and local) level is "alderman" and the equivalent of the Prime Minister is President.

(10) It is often said that inequalities have also increased among the LHUs of the same region; this is particularly true in regions which are politically heterogeneous, in which regional and local ruling groups include different parties.

the LHUs are outside the standard range of 50,000-200,000 inhabitants defined by the Reform Act; there are 195 LHUs with less than 50,000 inhabitants.

An important side effect of the high total number of LHUs has been the appointment to the Management Committees of low profile political activists (most of whom are not elected politicians) with very little previous administrative experience.

The NHP and the RHPs were supposed to be the main tool of coordination of the planning system. In practice, the first NHP has not yet been approved for a variety of reasons¹¹ and only 10 regions have approved RHPs. Needless to say, the RHPs cannot be consistent with the as yet non-existent NHP.

The "administrative paradox" has been that, without comprehensive plans (particularly the national one), the DoH and the Regional authorities have dramatically increased the legislative powers for controlling the system by regulations (Borgonovi, 1988). In practice the DoH and regional authorities have sought to exert control over the lower tiers of the NHS, by regulating practical processes (financing, marketing, etc.) in detail, instead of using broader tools (standardized indicators of performance etc.).

1.2.2 Managerial Problems at Local Level

One side-effect related to the adoption of the administrative model in the health care system has been the **"bureaucratisation" of the LHU**. In practice this means that every activity concerned with the "external environment" (managerial decisions such as purchase contracts, but also the simple application of national/regional health precautions) is "deliberated" by the Management Committee. The logic underlying the bureaucratisation is to guarantee the legitimacy, the openness and the honesty of the public sector. Apart

(11) Until 1983 the main reason of the non approval of the NHP was that the NHP was considered a law (and in Italy legislative processes can be very lengthy). However, notwithstanding the fact that since 1983 the law N.638 has established that NHP approval need not be considered a legislative act, we are still waiting for a NHP. The real reason seems to be the frequent changes in Italian Governments.

from the fact that bureaucratisation has not achieved this aim, the main practical consequence has been that LHU Management Committees have been involved in managing administrative activities, rather than in defining health care policies as was intended. This raises confusion in delineating the real borders between the political and the managerial roles (see later).

The structural model for the NHS which was proposed by the Reform Act is very interesting and modern, but also very ambitious. The plan to make the LHU responsible for all the health services was good in theory because it enhanced integration and coordination of services. However as a consequence the LHU has become a highly complex organisation providing many very different services and requiring varied managerial and professional skills. The need for vertical integration (prevention, diagnosis, treatment and rehabilitation) and horizontal integration (different services) is acute and calls for very strong management skills. Nevertheless, the Reform Act did not introduce any management training schemes. In Italy, there has never been a National School of Health and there are no teaching programmes run in other bodies which are officially recognized and funded by the DoH for NHS managers.

In effect, the post-reform situation has simply become an extension of the fragmented pre-reform services. This is discussed further in Section 2. However, here it should be noted that an important side-effect of this lack of integration is that medical information dealing with each patient does not circulate within the system between the health services involved, but is carried by the patient her/himself. S/he becomes a sort of "errand boy who sews together the various parts of the system" (Freddi, 1984), a very uncomfortable role inconsistent with the principles of the 1978 Reform Act.

It is impossible to generalize the managerial problems at the LHU level because Regions do not share a standard organisational structure; the total number of services provided by a LHU (including the administrative services) can vary, depending on the Region, from five to thirteen and this large variation cannot be explained completely by different local needs.

However the main structural problems have concerned the **functioning of the Directing Office** and the **role of the two Coordinators**.

The choice to have a group of people as top management has definitely complicated the decision-making process and sometimes prevented it from taking the most critical decisions.

The problem of the Health and Administrative Coordinators, who are also likely to be Directors of important services, is the lack of hierarchical lines (both up and down) and consequently the difficulty of clarifying their inter-relationship with the Directing Office and the Service Directors. This complex organisational situation has led to the acquisition of power by the more "charismatic" members of the Directing Office.

There are three other factors which influence the organisational performance of LHUs. Firstly the "bureaucratisation" of the LHU has made Service Directors and Coordinators feel less responsible for their managerial activity in relation to the "external environment". Secondly the coordination of health service provision and the social services (whether this takes the form of integration of social services inside the NHS or of simple cooperation between them) has created many organisational problems between LHUs and Communes. In the third place the lack of institutional autonomy of the LHU means that the LHU's assets are formally owned by the local authority, although managerial responsibility rests with the LHU's service Directors and Coordinators.

1.3 The Reform Project

1.3.1 Institutional Reforms

Because of the many problems described above and the ensuing debate, at the end of the 1980s the Government developed a project to "reform the reform act". This is considered to be the most important and radical project since the introduction of the NHS in Italy. Although it may be changed during the legislative process, the principal components are unlikely to be modified to any extent.

A number of important innovations affecting the institutional framework are foreseen:

1. **The modification of the territories of the LHUs.**

The total number of LHUs would decrease as the project lays down a minimum number of 120,000 inhabitants per LHU, although there could be exceptions in the light of particular conditions, on the advice of the DoH and regional authorities.

2. **The institutional autonomy of the LHUs.**

The LHUs will no longer be dependent agencies of the Communes, but autonomous organisations; consequently they will own the assets used for their activity.

3. **The modification of the LHU organisational structure.**

The top management will be represented by a **General Manager**, who will replace the Directing Office and will be supported in his/her activity by a **Health Manager** and an **Administrative Manager** (both appointed by the General Manager).

These senior executives will have a contract in private law which will last five years and will be renewable. This contract is substantially more flexible than the public one as regards the determination of pay, and includes the possibility of dismissal.

The General Managers will be chosen from those on a national list. To be eligible one must be a graduate and have worked for at least five years, with a record of achievement, either in private companies or in state-controlled companies or public administration.

The top managers will be supported by a **Council of Health Professionals** (nine to fifteen members, most of them medical doctors), who must be consulted about major initiatives, although their advice is not binding.

A **Board of Directors** will oversee the functioning of the LHU. While day to day

management will be the responsibility of the General Manager, the Board of Directors will be responsible for strategic issues and for ensuring that policy is implemented by the managers. Membership of the Board will vary from five to nine.

Figure 1.3 shows the new organisational structure of a LHU¹².

4. **Institutional autonomy of high specialty hospitals.**

Hospitals with highly specialised departments will become independent organisations with the same organisational structure as the LHUs. The criteria for being accredited as a high specialty hospital are related to the achievement of un-specified standards of activity, structure and personnel.

5. **Other features.**

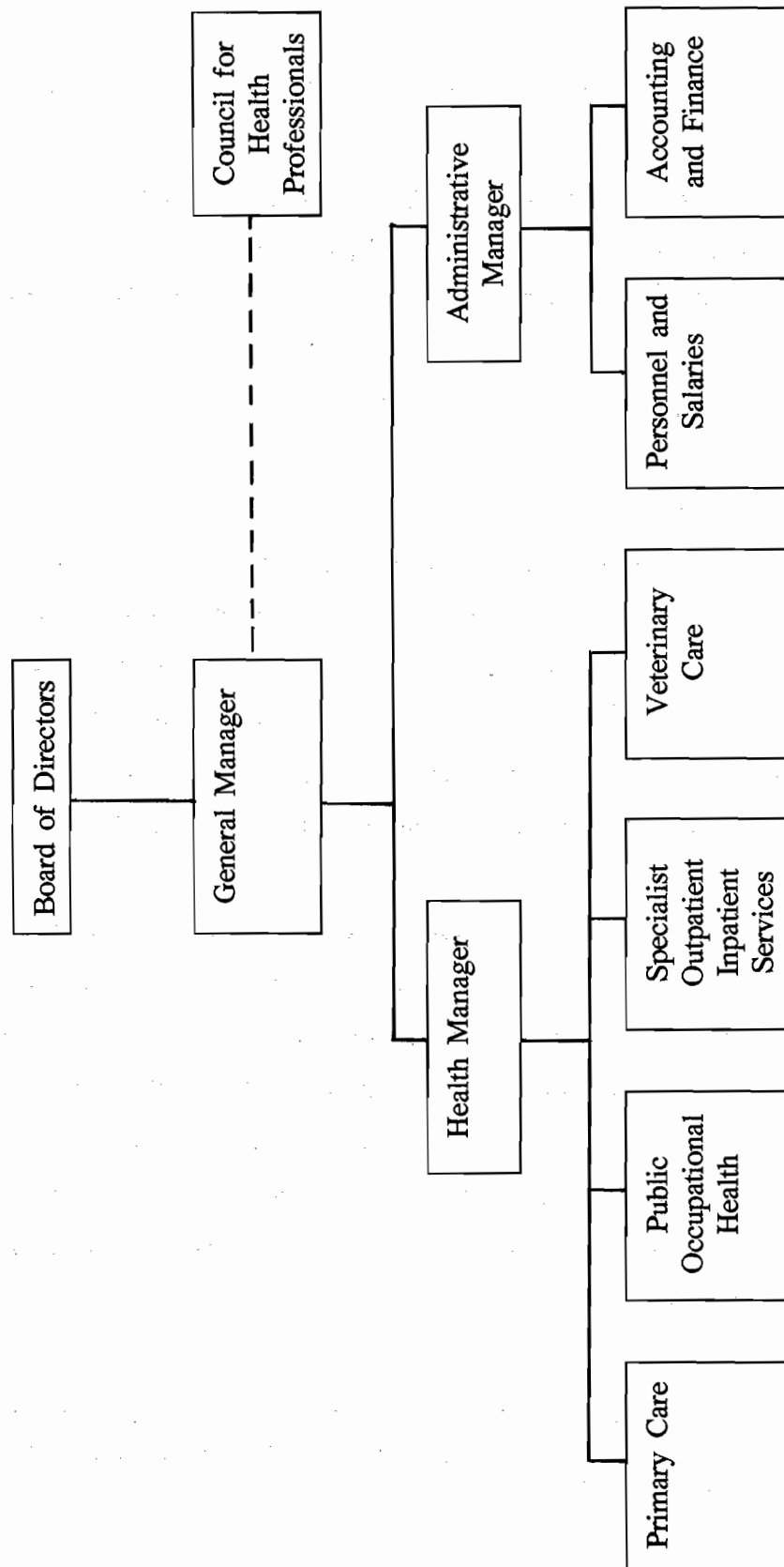
Teaching programmes for managers of the NHS will either be run by the Superior School of Public Administration (which until now has not specialised in health care programmes) or contracted out to universities and other bodies accredited by the DoH. From the patient's point of view, the Reform Bill Project requires the NHS to provide better information to the public, to adopt appointment schedules, to guarantee opportunities to speak to administrators and to defend their rights.

There are some positive points in the Reform Act Project, most of which are related to the problems mentioned in the previous section: the increased size of the LHUs, the transfer to the LHU of control of their own assets, a streamlined management structure, improved management training and the appointment of professional management personnel in place of political party nominees. From a general point of view the most important innovations are the opening up of the NHS to managers coming from the private sector, the possibility of changing senior managers and relating their pay to their performance (by adopting private law contracts).

(12) The Reform Project recommends changing the name of the LHUs to Health Services Companies in order to stress the importance of management in the new organisational structure.

Figure 1.3

EXAMPLE OF THE ORGANISATIONAL STRUCTURE OF A LHU AS SET OUT IN THE REFORM PROJECT



On the other hand it is necessary to emphasise that the project is couched in very general terms, and it is far from certain that things will really change. This is particularly evident in the vagueness of the criteria for inclusion in the list of potential General Managers and for recognition as highly specialized hospitals. Pressure by local politicians could lead to most of the existing managers being reappointed and the decrease in the total number of LHUs might be balanced by the creation of an excessive number of autonomous hospitals.

However, in the opinion of the author the main problems of the Italian NHS are broader than those addressed by the Reform Project. The crux of the matter lies in the relationship between the administrative system and the NHS and particularly the boundaries between the political and managerial roles.

1.3.2 Proposals for Further Reforms

As the autonomy of local authorities seems unlikely to decrease, particularly at regional level¹³, the most effective central policy would be to work out a few but precise "rules of the game", for instance a qualitative and quantitative definition of the minimum set of services which are required to be provided at the regional level, the criteria used for financing the system and the institution of compulsory training schemes for NHS managers.

At the same time the DoH should start a process of deregulation, by dramatically decreasing both the regulations and the formal controls which limit managerial activity and lead to a high degree of bureaucratic activity inside the LHU. In practice strict regulation (typical of the Italian administrative system) presents a rigid framework which does not

(13) Apart from the fact that autonomy of Regions and Communes is recognized by the Italian Constitution, the successful electoral performance, particularly in Northern Italy, of the 'regional leagues', (parties which defend regional interests) make it very unlikely that territorial autonomy will decrease.

enable the system to find internal managerial solutions to the problems. This does not help the development of managerial skills inside the system and slows down any organisational improvement.

More effective and helpful activities at the national level (as foreseen in the Reform Project) could be:

- (i) To fund experiments on managerial and organisational tools that can potentially improve the performance of the NHS (cost accounting, clinical budget, medical audit etc.) and to promote examples of good practice;
- (ii) To strengthen the information system for assessing regional performance and for enhancing the openness of the system (for instance by the monitoring and publication of prices of goods purchased at the local level)¹⁴;
- (iii) To organise compulsory training schemes for managers and physicians employed by the NHS (in particular for new employees), in order to enhance an effective improvement of the system internally through the development of improved managerial and professional skills¹⁵.

The Regions seem to be the most appropriate local level for planning health services, given the Italian institutional and political situation. Their main activity could be to set out the guidelines for strategic activity of LHUs' General Managers. Criteria for allocating financial resources among the regional LHUs should take account of the performance of local services compared with regional guidelines. National contracts for

-
- (14) With regard to the information system, it is necessary to underline the importance of having available significant data. It would be useful to introduce some sort of objective responsibility for data related to structure (for example number of beds in hospitals) and process (for example number of admissions and days of stay in hospital), and not only for data related to expenditure as foreseen at present.
 - (15) Given the special requirements of the health care sector, the managerial skills available outside the NHS would not be adequate and managers coming from the private sector would need specific training.

personnel and health services (see next Section) should be less rigid and give some scope for regional negotiations; more radically, contracting out of outpatients specialist care and hospital services should be a regional task, because it encompasses decisions related to local needs and local planning activity. LHUs would become autonomous regional agencies. Consequently the role of local politicians and political party members should be limited to advocacy on behalf of the population¹⁶. This would avoid their local interests interfering with the planning and the management of the system.

2 THE MAJOR SERVICES

Before discussing the three major components of the NHS (primary care, outpatients specialist care and hospital services) it is important to consider some points about the information system for health care in Italy, in order to explain the choice of sources and figures used in the main analysis.

The National Institute of Statistics, **Istat**, is a traditional source of information: it publishes figures related to hospital activity, projected from a temporal sample (the first week of each month) and non disaggregated at the LHU level. Since 1984 an additional source has been the **Central Service for Health Planning** at the Department of Health. This is considerably more analytic, it provides figures for expenditure (see Section 3) and covers all LHUs.

However reliable figures are still not available for some aspects of the health care system due to "teething problems" with the information system. For this reason figures about NHS personnel, for example, cannot be included in this paper. Furthermore, trend analysis is not reliable because changes from one year to another are principally due to random variation. Consequently, Istat figures have been used for trend analysis and the

(16) Another possibility could be to remove local politicians and political nominees from the NHS. However this seems a very unlikely solution as it implies legislative turmoil, i.e. to formally remove Communes from the health service.

Department of Health data have been used for regional analysis¹⁷.

2.1 Primary Care

Primary care was one of the priority targets of the Reform Law. In fact preventive medicine, which is a central theme of the law, is most commonly provided in a primary care setting.

Districts, which are components of LHUs, should be the first organisational level at which the health needs of patients are related to health service provision. However the District is not specifically defined in the law and the definition given below is derived from the Reform Project.

The District is the functional division of the LHU at which primary care is provided and coordinates care provided by General Practitioners (GPs), GP Paediatricians (see later), counselling centres for family planning, nursing home care and local social services; the District also provides integration between primary and specialist care, health promotion and epidemiological surveillance. In practice Districts should enable horizontal integration of all primary care services.

In the absence of precise regulations, Regions have had considerable autonomy in the extent to which they have established Districts, and this has led to widespread variation. In general, few of the southern Regions (the poorest ones) have established Districts so far. Most of the central and northern Regions have established Districts, although there is still considerable variation between different Regions.

However throughout the country the successful establishment of Districts has been very rare, since the Regions and LHUs have been unwilling to devolve power to District level. Where Districts have been working successfully this is due primarily to the skills

(17) The author worked for three years for Bocconi University as a consultant of the Central Service for Health Planning; during that period he gained considerable knowledge of the validity of the data.

and creative leadership of the District Co-ordinator.

2.1.1 General Practice

General Practitioners are the major source of expenditure in primary care. In Italy there are two kinds of GPs: GPs who care for adults and GP Paediatricians (GPs with special qualifications in child health) who look after children under the age of fourteen. Their duties, numbers and pay are determined by two separate triennial national contracts.

GPs, who are self-employed independent practitioners, are paid solely on a capitation basis¹⁸ and do not receive any reimbursement for the costs of their premises and personnel. The level of capitation payment increases with the seniority of the GP (taken as years since graduation).

GPs can work full-time or part-time, but certain categories of doctors are prevented from working as part-time general practitioners, as there may be a potential conflict of interest.

The general practice service is limited to mornings (Saturday included) and afternoons of weekdays. The new contracts introduce additional items of service fees; all GPs will also be paid for about twenty minor operations (thirty in the case of GP Paediatricians), for instance wound suture, nose tamponade, phlebotomy application, but not for diagnostic tests; this expenditure will be monitored every six months¹⁹.

GPs usually work single-handed. Even though the contract foresees the possibility that some may share clinic premises with one or more colleagues, the element of competition, resulting from the practice whereby patients are registered with one doctor

-
- (18) Small extra payments are also available for working in unattractive or sparsely populated areas.
 - (19) Additional payments were introduced for the first time in the previous contract, and included more operations and also diagnostic tests. However the dramatic increase in expenditure obliged the DoH to cease payments after a few months.

alone mitigates against this.

Full-time GPs can have a maximum list sizes of 1,500 patients, but part-time GPs, who are also working in public hospitals, are limited to 500 patients. However some GPs who had many more patients than the present maximum in the pre-reform period, are still allowed to have 1,800 patients. For GP Paediatricians the maximum list sizes are 800 children for those in full-time work (or 1,000 for those who previously had many more patients) and 350 for part-time GPs who also work in public hospitals.

Patients can choose their GP and change to a different GP without having to give an explanation. GPs have considerable control over all further care given by the specialist outpatient clinics²⁰, as they are required to approve all referrals for consultations, investigations and prescriptions of drugs. This increases their administrative workload and inconveniences patients who have to return to their GP each time for validation of prescriptions from specialists. Under the new contract, specialist doctors are allowed to prescribe urgent and necessary drugs without authorisation. Table 2.1 shows the number of GPs and GP Paediatricians and their geographical density in 1987 for macro areas²¹.

There are 59,128 GPs and 4,679 GP Paediatricians in Italy. The number of GPs per 1,000 adult inhabitants is 1.2, slightly higher than the standard of 1.0 laid down in the previous contract. The number of GPs per 1,000 of the population is greater in the southern area (1.4), where they have correspondingly fewer patients each.

(20) Outpatient care is often delivered in health clinics, staffed by specialists; rather than in hospitals as is the case in Britain.

(21) Regions have been aggregated in a slightly different way than that of Istat, in order to make the macro areas more homogenous the macro areas from a health care point of view. Emilia-Romagna has been included in the central area (and not in north-eastern area) because hospital services in this region are less relevant than in the north-eastern area. It is important to underline that macro areas are just an effective way to present rational figures, but they have no meaning from an institutional point of view.

Table 2.1**GEOGRAPHICAL DISTRIBUTION AND DENSITY OF GPs AND GP PAEDIATRICIANS**

	GPs	GP Paediatr.	GPs per 1000 adults	Paediatr. per 1000 children	Total GPs per 1000 inhabitants
North-West	15,384	1,169	1.14	0.64	1.08
North-East	5,233	437	0.98	0.63	0.93
Central	15,285	1,265	1.02	0.64	0.97
South	23,226	1,808	1.39	0.46	1.22
Total	59,129	4,679	1.17	0.56	1.08

Source: DoH (Central Service for Health Planning).

There are 0.6 GP Paediatricians per 1000 children nationally, a rate which is less than half of the norm of 1.4 laid down in the contract²². In many regions there is a considerable shortage of GP Paediatricians, suggesting that GP paediatrics is a potential area of expansion. The shortage of GP Paediatricians suggests that many GPs still look after children. However the new contract introduces a major change as only GP Paediatricians will be allowed to look after children under six.

The main problem for GPs is that they are (and feel themselves to be) still isolated inside the NHS, a sort of appendix to the health care system. They have very little opportunity to be involved in LHUs' activities and they have no formal relations with specialist care (outpatient clinics and hospitals). The proposal in the new GPs contract for integration of home care assistance with specialist doctors for terminal, mentally ill and elderly patients is therefore to be welcomed. However collaboration with specialist doctors, hospitals and outpatient clinics should be more frequent; in particular, the exchange of information about patients between GPs and specialists should be compulsory in order to

(22) More precisely, the standard mentioned in the contract is 1 GP Paediatrician per 700 children under twelve.

enhance real integration throughout the service.

Italian GPs start practising with very little clinical experience, which is obtained between the end of university and the public national examination which it is necessary to pass in order to be allowed to practice (54 months apprenticeship in the overcrowded Italian teaching hospitals²³). Thus, their ability to diagnose correctly is often very low. Continuing education for GPs on courses provided by the LHUs is rare and the main source of information on new developments is from pharmaceutical companies.

Motivational surveys show that most GPs are badly motivated and consider their work to be administrative, rather than medical; general practice is seen as a way of earning money, and other activities (including leisure) are their major goals.

The capitation system encourages this situation. GPs have a major incentive to minimize the time spent with patients, without losing them to another GP. Consequently the easiest way to satisfy patients, consistent with their low diagnostic ability, is to prescribe whatever patients want (drugs, consultations or investigations). This behaviour is "appreciated" not only by most of the patients, but also by the private sector, outpatient clinics and particularly pharmaceutical companies. GPs are a major target of pharmaceutical companies, leading to relationships of dubious ethical value.

Local scrutiny of the expenditure incurred by GPs and the prescription charges paid by patients could be used to interrupt the circle between GPs and private organisations which generates consistent expenditure, but such controls have not worked. Local control is difficult because only ten regions are equipped with the necessary computer software and hardware. These data bases are used mainly for epidemiological studies and administration (particularly reimbursement to pharmacies), rather than for management i.e. control of the

(23) Italy has a high unemployment level among physicians; the number of matriculations is the highest in Western Europe. This is the result of lack of planning of the number of students in the faculties of medicine, the admittance to which has been limited only recently.

system to ensure the cost effective delivery of care. There is no systematic programme to control GPs prescriptions and, as far as it is known, very few GPs have been punished until now, and then only for obvious collusion with pharmaceutical companies.

However the major reason for lack of local control is probably that Regions and LHUs have never been motivated by appropriate incentives to control this kind of expenditure.

2.1.2 Pharmaceutical Expenditure

Pharmaceutical expenditure is an exogenous variable determined at the national level, through tools such as the National Therapeutic Formulary and the National Price Scheme. The National Therapeutic Formulary (NTF) is the list of drugs which can be used in the NHS. Drugs are divided into three categories related to a different prescription charge (the so-called "ticket") which has to be paid. The first category includes a very narrow range of essential drugs (about 2% of drug expenditure) which are excluded from prescription charges. The second category includes mainly serums and vaccines and the prescription charge is 30%. The vast majority of drugs are included in the third category, for which the prescription charge is 40%²⁴. The number of categories and the amount of "tickets" has varied continually during the last years.

Prices for each drug are regulated by central authorities, through the Interministerial Committee of Prices. The pricing system is based on the determination of production costs. Some of these costs, eg materials and labour, are assessed at the level of average costs throughout the sector. Other costs are expressed in percentage terms with a view to encouraging certain activities of the pharmaceutical industry (research and development) and discouraging others (promotion). It is not an aim of this publication to assess the

(24) In addition to the "ticket", a flat rate charge of 3,000 lire (about £1.50) has to be paid for each prescription. A prescription may cover a maximum of three items. The "ticket" charge and the flat rate charge for each prescription must total no more than 40,000 lire (£20). Patients have to pay the "ticket" not only for drugs but all medical supplies, outpatient care and all investigative tests (see Section 2.2).

pharmaceutical policy of the central authorities. However it should be noted that the pharmaceutical industry has been very successful in including in the NTF many new products which clinically differ only slightly from established drugs and for which they charge higher prices.

In general decentralisation of financial control within the NHS has not led to improved control of expenditure at local level. The southern regions (which are the poorest and therefore the ones benefiting most from the model of allocation of financial resources) are those with significantly higher public pharmaceutical expenditure and prescription per head as Table 2.2 shows (this will be considered in detail in Section 3.2).

Table 2.2

**GEOGRAPHICAL DISTRIBUTION OF PHARMACEUTICAL EXPENDITURE
PER CAPITA, PRESCRIPTIONS PER CAPITA (1987)**

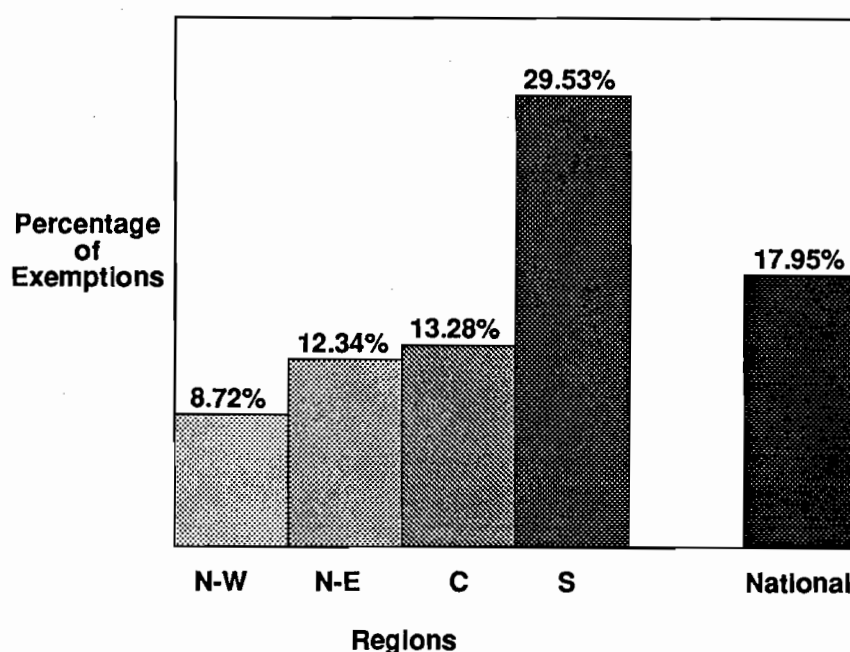
	Gross Expenditure Per Capita	Index (National Base = 100)	Prescriptions Per Capita
North-West	163,566	92.2	7.69
North-East	147,851	83.4	7.62
Central	181,423	102.3	8.70
South	193,159	108.9	9.39
National	177,332	100.0	8.57

Source: DoH (Central Service for Health Planning)

Even though "tickets", have been increased considerably during the 1980s, the large percentage of people who are exempted (18% of the total population in 1987, rising to

25% in the last year)²⁵ and the high level of expenditure associated with them (according to estimates of the chemist's association, they comprised about 85% of public pharmaceutical expenditure in 1989) have dramatically reduced their effect. In southern regions, where exemption is more frequent (Graph 2.1), this is mainly due to families who have one member exempt but obtain prescriptions for the whole family through the exempt individual and thus bypass "tickets".

GRAPH 2.1
PERCENTAGE OF EXEMPTIONS (1987)



Source: DoH (Central Service for Health Planning)

2.1.3 Medical Guard and Tourist Guard

Some components of primary care are also delivered by the 'medical guard' and 'tourist guard'. The medical guard provides out-of-hours care, defined as care for urgent calls from 2pm on Saturday to 8am on Monday (with similar arrangements for other

(25) Exemptions are allowed for three main categories: people with a low income, people in particular categories (for instance, invalids) and people with fixed pathologies (for example, diabetes mellitus and multiple sclerosis).

holidays) and from 8pm to 8am on weekdays. The tourist guard provides further primary care in tourist localities, to cover non-residential patients. For both services doctors are paid on a hourly basis.

The doctors employed in these services are usually young. This is partly because of the unsocial hours of the work, but also because the selection rules for applicants give an extra weighting to young or recent graduates unable to find a practice themselves and needing to gain experience (they are not allowed other contractual full- or part-time employment, including general practice). While the services fulfil a role in providing employment for young unemployed doctors, the lack of experience of these doctors suggests that they are not the most appropriate doctors to be giving emergency care. As a result the definition of a specific full-time role for emergency care which is foreseen by the new contract could be a cause for concern.

2.2 Specialist Outpatient Care

Specialist Outpatient Care through the NHS is delivered in three different facilities: hospital clinics, non-hospital public specialist outpatient clinics, and specialist outpatient clinics.

It is very difficult to obtain details of expenditure and activity in this service, because systems of payment are completely different from one facility to another, as will be shown in the following analysis. Consequently this is the service for which lack of figures is most relevant.

2.2.1 Non Hospital Public Specialist Outpatient Clinics

Most of the **Non Hospital Public Specialist Outpatient Clinics** were set up by public insurance schemes in the pre-reform period and mainly served the working population. Even though they can be considered an inheritance from the pre-reform system, outpatient clinics are potentially useful facilities in local situations, particularly in the absence of general hospitals, where they act as a form of autonomous day hospital.

Situated in their own premises, they are convenient for the patients and can facilitate integration among the different specialties.

However, in practice the situation is very different. Outpatient clinics function as a collection of specialist doctors who work there, with any integration deriving only from personal relationships. There is no formal management role to enhance coordination of medical activities. Some of the doctors are employed by the NHS, but the vast majority of the specialist doctors are **internal contracted specialists**²⁶ (18,000-20,000 physicians, according to the last public estimates). Most of them were previously specialists in the public insurance system of the pre-reform period.

Their terms of service are set out in a triennial national contract. They are paid on an hourly basis²⁷, regardless of their actual activity; they can work for more than one LHU and more than one outpatient clinic in an LHU and they can also be employed as part-time hospital doctors. The LHUs determine their weekly total amount of hours (a maximum of 38 hours, including thirty days of paid holiday).

Theoretically these hours are determined on the basis of need for services, but in practice they are related to historical trends. In fact LHUs can only reduce the contracted hours if the total number of annual visits progressively fall for reasons outside the LHU's control. Moreover, it is important to underline that all the full-time contracts before 1984 are personal and non-rescindable, which is an important constraint on the discretion of the LHU: the flexibility of LHUs is limited to moving doctors from one outpatient clinic to another.

Consequently the regions where contracted hours determine a considerable expenditure are those where these specialists were historically numerous. As Table 2.3

(26) These contracted specialists are called "internal" because they work in public outpatient clinics, whereas contracted specialists are called "external", because they work in private premises.

(27) As with GPs, small extra payments can also be available for working in unattractive or sparsely populated areas.

shows, the contracted hours per 1000 patients is very high in the central area.

Table 2.3

**GEOGRAPHICAL DISTRIBUTION OF CONTRACTED INTERNAL
SPECIALIST HOURS PER CAPITA AND CONTRACTED EXTERNAL
SPECIALIST EXPENDITURE PER CAPITAL (1987)**

	Hours Per Capita	Index National Base = 100	Expenditure Per Capita	Index National Base = 100
North-West	232	87.9	21274	57.7
North-East	216	81.8	20877	56.6
Central	330	125.0	34664	94.0
South	253	95.8	54357	147.5
National	264	100.0	36862	100.0

Source: DoH (Central Service for Health Planning)

The role of full-time specialists is limited to diagnosis because they are not permitted to perform minor operations and they do not follow up patients in hospital. Consequently medical specialists have little opportunity to improve their diagnostic skills and surgical specialists lose their ability to perform the interventions learnt during their training. Moreover, hospital doctors consider them to be second-class doctors and of limited diagnostic skill. Therefore they tend to repeat investigations on patients who are admitted in order to check the diagnosis.

Under the new contract passed at the end of 1990, internal contracted specialists will be allowed to provide home care in association with GPs, to prescribe drugs and order investigations (see previous Section) and also to perform some minor operations (a total of 197 for all the 40 specialties included in the contract).

An alternative approach for the resolution of the problems of outpatient clinics is

the incorporation of internal contracted specialists within the NHS. Their role is simply a vestige of the past and is incompatible with the present situation. Moreover, there is a need for a health manager in the outpatient clinic, who will co-ordinate activity among the specialists and facilitate more efficient use of resources.

2.2.2 Private Clinics and Specialist Outpatient Clinics

Private Clinics and Specialist Outpatient Clinics (or **external contracted specialist services**) are a very heterogeneous category. Their status can vary from that of a specialist doctor who works single-handed, to that of a contracted private hospital (see next section), to that of a large company which employs many doctors in different specialties and provides both consultations and investigations.

This is the sector of activity about which least is known. Even the total number of units (considering one unit as either a doctor working alone, or private hospitals, or companies) is uncertain, and the official figures of 8,400 units for consultations and 9,000 for pathology and radiology services are very likely to be overestimates. What can be said is that the vast majority are specialists working single-handed, most of whom work in the southern area; conversely the majority of the large clinics are located in northern and central areas. Figures of per capita expenditure given in Table 2.3 show that per capita expenditure on private specialists services is very low in north-western and north-eastern areas, whereas it is dramatically high in the southern area.

The Reform Law states that, if an appointment is not available in the public facilities within three days²⁸, the patient may use a private contracted specialist. Private facilities can, therefore, be considered to be complementary to the public facilities.

However, as the specialists at the public hospital and outpatient clinic may be the

(28) Since 1988 this has been changed to four days in order to limit recourse to private contracted specialists.

same as the specialists in private practice (or their close colleagues)²⁹, these arrangements are open to abuse. A typical expedient to bypass the "three day" rule is to include in prescriptions tests which are not available within three days in the public facilities of the area where the patient lives. The patient is therefore entitled to obtain treatment from a private contracted specialist.

Private contracted specialists are reimbursed per attendance and the cost of individual consultations and investigations are determined centrally, through a national contract which is renewed infrequently by the DoH.

If prices are determined at central level, effective management might be enhanced if the volume of activity was controlled at local level. But, for the reasons indicated in Section 3.2, local control is almost completely lacking and the situation is similar to that of pharmaceutical expenditure. However unlike pharmaceutical expenditure, central regulation works better in this "market" for two reasons. Firstly it is more difficult to overcome the deliberate holding down of fees. In fact the only possible (but very complicated) strategy to maximise income is to shift the mix towards more profitable investigations. Secondly, the "ticket" is much more effective in reducing consultations than prescriptions. As consultations and investigations are a personal service, it is impossible for those exempted to use the "ticket" on behalf of other people.

2.2.3 Public Hospital Clinics

Public Hospital Clinics probably provide the least important component of specialist outpatient care (except in some northern regions).

Provision of outpatient care in public hospitals is related to the **Productivity Incentive**, introduced in the national labour contract of 1983. This incentive is intended to increase the provision of specialist outpatient care inside hospitals (both consultations

(29) Even though full-time public hospital doctors are not allowed to work in private facilities, it seems that many of them do not respect this condition. They may even own private clinics, using figure-head doctors to conceal their involvement.

and investigations) through overtime, in order to decrease the referrals to private premises. For this reason the total amount of money assigned to overtime payments is formally a percentage of external contracted specialist expenditure.

In practice this incentive has been used to enable NHS personnel to increase their income through overtime payments, since in Italy the basic income of all public employees is expected to rise at less than the inflation rate as part of national economic policy³⁰.

The amount of money assigned for overtime payments regionally is negotiated between regional authorities and trades union representing NHS personnel. Moreover, these extra payments are distributed not only among all the employees of the services where outpatient care is delivered, but also among other services if certain "ceilings" of activity (usually targets which are very easy to achieve) are exceeded.

The Productivity Incentive has increased specialist outpatient care in hospitals, however, it is unlikely to have led to decreases in private outpatient care for the reasons mentioned above. Detailed figures regarding this are not available.

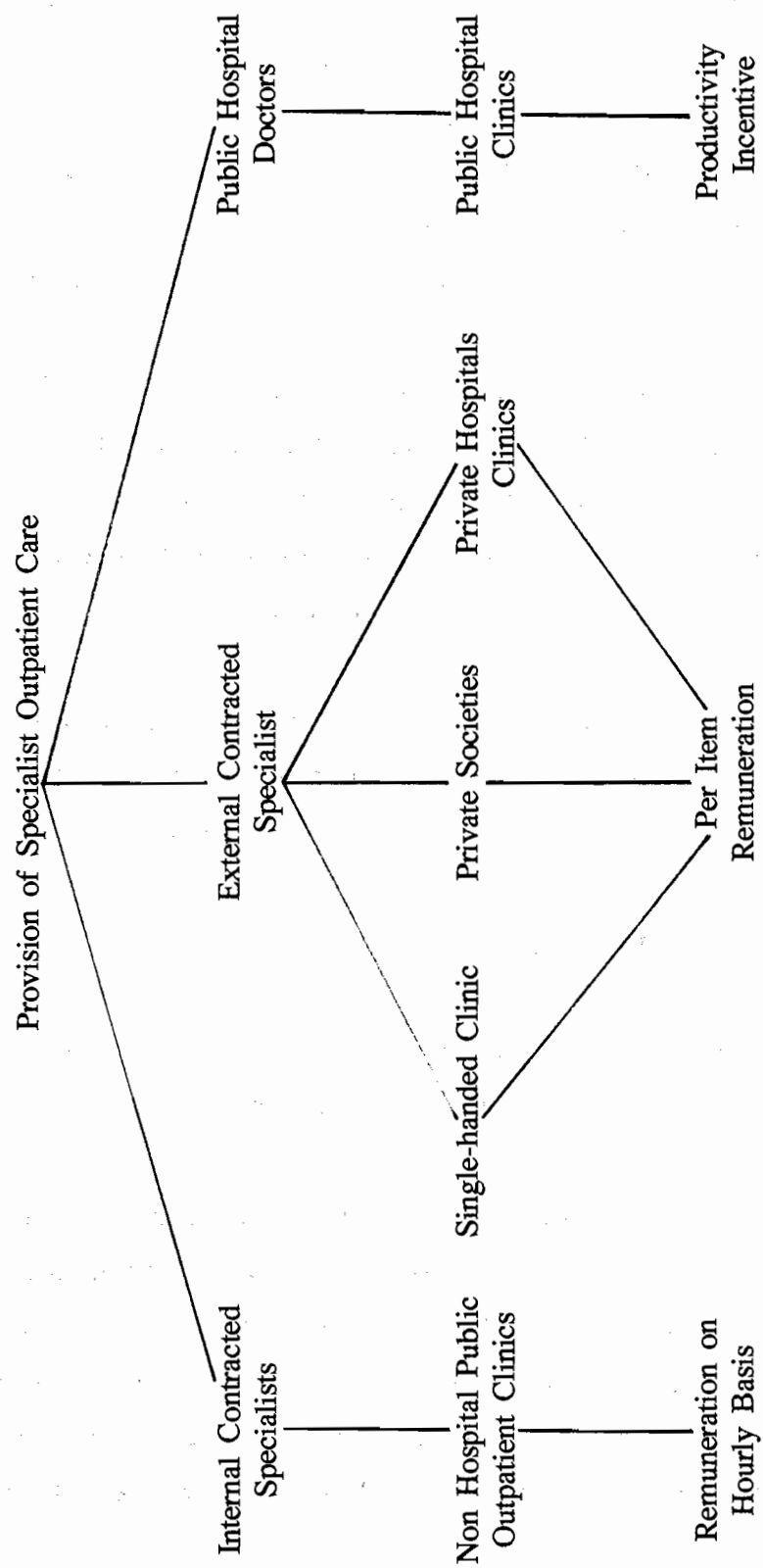
2.2.4 Administrative Procedures and Charges

Figure 2.1 summarizes the structures and methods of funding related to the three different kinds of doctors who can provide outpatients specialist care.

Referrals for specialist outpatient care can only be made by the patient's registered General Practitioner; specialists cannot refer patients to each other (see Section 2.1.1). To visit a specialist, the patient must present a GP's prescription to an office of the LHM and book an appointment. This is a rather time-consuming procedure for the patient when, as is usually the case, the booking has to be made in person and cannot be arranged by telephone. Moreover, as the patient him/herself collects reports of investigations and brings

(30) Although under the last national health contract passed in 1990 basic pay increased by an amount greater than the rate of inflation.

Figure 2.1



them to the doctor (specialist or GP), he or she can read the results which often leads to negative psychological results for the patient.

A charge for pathology and radiology tests was introduced for the first time in 1982 and since then it has frequently been abolished and then re-introduced. In 1989 it was introduced once again and has contributed significantly to freezing the dramatic increase which had occurred following the renewal of the contract of private external specialist care in 1987 (see Section 3.3).

The rate of the "ticket" for pathology and radiology tests is at present 30% of the fees paid to the private specialists up to a maximum of 40,000 lire (around £20); for specialist visits there is a charge of 15,000 lire for each one.

2.3 Hospital Services

Patients can choose which hospital they want to be admitted to (inside or outside their region), although the Reform Law states that patients should normally use services provided by the LHU in which they reside; they have the right to go to any LHU when they are temporarily residing elsewhere, in case of emergency or for similar specified reasons³¹.

There are five different kinds of hospitals working for the Italian NHS: public hospitals, private hospitals, scientific institutes, classified hospitals and university hospitals.

2.3.1 Public Hospitals

Public Hospitals number 1,147 (61% of the total) and represent 79.3% of the total beds, with an average size of 303 beds. As directly managed units of LHUs, they do not have an independent budget. Their organisational structure was laid down in laws passed

(31) As far as it is known, patients have hardly ever been required to specify reasons for using a different LHU.

in the 1970s, before the Reform Act.

The **Health Manager** (who must be a physician) is responsible for hygiene and health in the hospital and promotes coordination among the different wards, clinics and services; he receives advice from a **Council of Health Professionals** (composed only of physicians). Each **ward** is managed by a **consultant** who is managerially and medically responsible for all of the personnel working within it. **Senior registrars** and **registrars** are the other medical doctors who work in a ward; besides their medical responsibilities also help the consultant in his or her managerial duties. The **head nurse** is directly responsible for nurses; s/he is accountable directly to the consultant.

The same structure is applied to **clinics** related to wards, which can also be used by medical doctors for their private activity.

The number of **services** available in a hospital is related to its size. However the presence of reception, emergency, radiology, pathology, transfusion and anaesthesia is compulsory in all the hospitals.

Integration of the activities of inter-linked wards and services should take place through **departments**. The importance of this function has been stressed by the Reform Law. The department is managed by a **Directing Committee** (composed of the consultants of the wards and services involved in the department, some senior registrars and registrars) which can appoint one of its members as Coordinator of the Department.

Problems related to this organisational structure undermine coordination of different activities inside the hospital (Burani, 1988). The role of the department is not clearly defined. As the hierarchical structure within wards and services is very strong, departments have always been considered of secondary importance. As a result, even now (twenty years after the law first introduced them) very few departments have been set up and even fewer work effectively. Thus in practice there is little integration among the activities of the different wards and services and such integration as does exist is most often based on personal contacts. Wards can be still considered "hospitals" within a hospital, with

considerable problems of integration with primary care and the exchange of information between physicians; in particular, Italian hospitals are still exclusively "physician oriented", and not "patient oriented". The Reform Project (see Section 1.3) does not clarify this problem.

The real power of the health manager is poorly defined, given the autonomy of the consultants. The roles of the health manager and of consultants call for organisational and managerial skills which most Italian physicians lack. In the case of consultants, this has led to very different styles of behaviour at ward level, depending on the consultant's personality, such as refusal/acceptance/delegation (to senior registrars or head nurses) of the managerial role.

There are two general problems in all Italian hospitals. The first is operational and has contributed to the phenomenon of "useless admissions": the reception of both urgent and non urgent admissions by the emergency service (Burani, 1988). The problem is that doctors who work in the emergency service cannot adequately perform the task of admitting non urgent patients. They do not have all the specialist medical knowledge necessary to assess the need for admission of any given patient and they do not know the availability of beds in the wards and theatres (information which is particularly important for surgical wards). As a result, patients have to accept the referral of the doctor, even though they may be doubtful of its accuracy, and patients in surgical wards often have to wait for some days in hospital for their operation. A possible solution to the problem would be to give the task of admission to each ward with a doctor assigned to deal with admissions each week-day morning.

The second and more important problem is that hospital doctors are allowed to choose between full-time (38 hours per week) and part-time (29 hours per week) contracts and, in the latter case, can also work for private hospitals³². According to Istat, part-time hospital doctors comprised 42.1% of the total in 1987.

(32) However it seems that many full-time hospital doctors do not respect this condition and also work for private facilities (see also footnote (29)).

Doctors who work for both public and private hospitals are poorly motivated when they work for the former and maintain their appointment mainly for prestige and safety, while the second is more profitable. Predictable issues arising from this situation are that dual status doctors discourage public hospitals from pressing vigorously for improvements in public premises and opportunistically exaggerate to patients the inability of public facilities to provide adequate care, including outpatient specialist care.

A side effect of this problem seems to be a shift of patients (particularly for surgical operations) from the public to the private hospitals; the arguments used to convince patients include better hotel comfort and allegedly shorter waiting lists. The fact that the use of the private sector is higher where the proportion of public hospital doctors with part-time status is higher corroborates this observation. A solution to the problem could come from the Reform Project, which should prevent people from working both for the public hospitals and in the contracted private sector.

2.3.2 Private Hospitals

Private Hospitals numbered 652 in 1987, 34.8% of the total, but their average size is very small (106 beds) and they represent just 15.8% of the total beds. In contrast to public hospitals, the majority of doctors in private hospitals work part-time. In fact full-time doctors account for only 25.3% of the total according to Istat.

In general the private sector has three advantages over the public hospitals (France, 1988). Firstly private hospitals have greater flexibility in matching the supply of medical staff to the demand for care. Secondly their labour costs are lower since social security contributions are already paid by the public sector. In the third place training of doctors is undertaken and financed by public hospitals.

Private hospitals are reimbursed per bed day. The daily rate is determined in a triennial national contract and is therefore the same throughout the country. Rates are in three bands relating to the classification of the hospital; these are related to the range of specialties provided in the hospital, the specialization of physicians and the quality of hotel

services. However private hospitals can obtain useful supplementary revenue from non-medical extras paid by the patients (additional nursing, more varied diet, etc.).

The contribution of private hospitals to NHS activity is decided at regional level. In fact regional authorities determine how many beds will be used for each specialty and how many days of stay will be budgeted for.

According to Law 595/1985 (see later) the role of private hospitals is formally complementary to rather than competitive with that of public hospitals. Details of the activity of these hospitals and the result of their system of reimbursement will be described later, but it should be noted that they do not usually have emergency departments and that they can be contracted for external specialist care.

2.3.3 Scientific Institutes

Scientific Institutes, numbering 32 (1.8% of the total) and representing 2.5% of the total beds, conduct biomedical scientific research activities, in addition to hospital activity. Recognition of their "scientific status" is determined by both the DoH and the Ministry of University and Scientific Research. Previously they may have been either public or private hospitals.

The LHUs in which they are located are obliged to contract with them, but they also work with other LHUs; they are considered to be "multizonal bodies". These hospitals are financed centrally for research and developmental activities. For hospital services, public institutes are paid by the Regions with a budgetary system, whilst private institutes are paid in the same way as private hospitals.

2.3.4 Classified Hospitals

Classified Hospitals, numbering 43 (2.3% of the total) and representing 2.4% of the total beds, had special contracts before the reform; most of them are religious hospitals. The Reform Law recognized their special status and the LHUs in which they are located

are obliged to contract them.

Classified hospitals are financed in the same way as private hospitals.

2.3.5 University Hospitals

University Hospitals can be either autonomous hospitals, or wards inside public hospitals; therefore it is impossible to count them separately and in the following quantitative analysis they will be considered as public hospitals. They provide clinical teaching for medical staff. Stipulation of contracts involves both Universities (for teaching) and Regions (for hospital services).

2.3.6 Trends in Hospital Activity

Figure 2.2 summarizes the methods of funding and the relative importance of the different types of hospitals working for the NHS. The organisation of hospital services described above was determined before the Reform Law; thus the NHS has just recognized the "status quo" and suited it to the new institutional framework.

The major laws concerning planning of hospital services from the post reform period are Law 595/1985 and Law 109/1988. The former is the most important law concerning the broad matter of planning (in the absence of the NHP); in particular, it lays down broad hospital standards of structure, activity and efficiency. The latter lays down standards of medical and nursing personnel per hospital bed. Unfortunately in the absence of reliable personnel statistics it is not possible to analyse these figures in detail. On the basis of ministerial calculations, the application of these standards should increase the present number of NHS personnel by around 100,000 (including approximately 13,000 physicians and 68,000 nurses), from the present estimate of 623,000 (which includes 82,000 physicians and 232,000 nurses). As recruitment of NHS personnel has been frozen since 1983, it is difficult to understand the logic of this law which foresees an increase of around 15% in personnel. In fact this law is inconsistent with the financial policy of these years (see Sections 3.1.2 and 3.3) and has never had any practical consequences.

Figure 2.2

DIFFERENT TYPES OF HOSPITALS WORKING FOR THE ITALIAN NHS

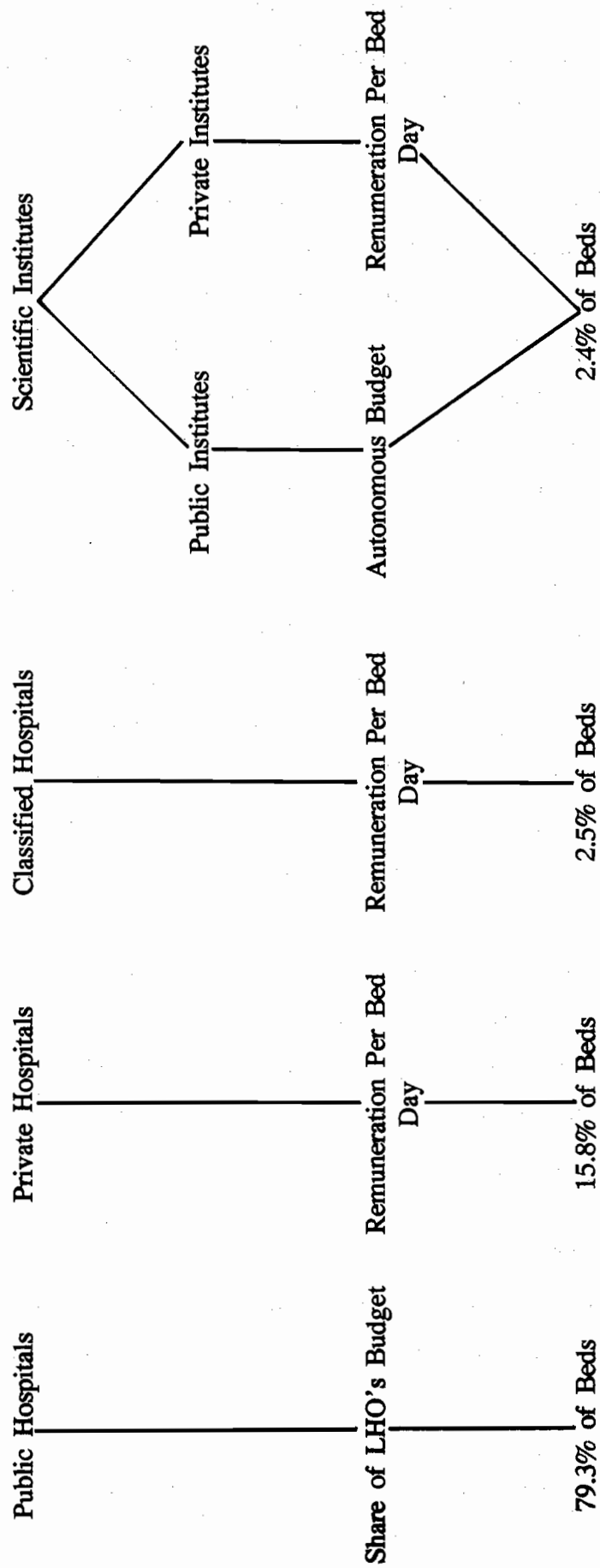


Table 2.4 shows the number of beds, admissions and days of stay during the period 1984-1988, with figures disaggregated by type of hospitals (non-psychiatric and psychiatric hospitals) and ownership (public and private hospitals).

In 1988 there were 424,417 hospital **beds** in Italy; the number of **admissions** was 9,532,211, involving 111,075,960 **bed days**. All the numbers have declined during the period 1984-88 (-11.8% in beds, -2.5% in admissions and -8.7% in bed days). Although these reductions are concentrated in **public hospitals** (in the **private hospitals**, beds diminished very slightly, -0.8%, while admissions and bed days increased, +4.5% and +0.6%), these hospitals still represent the overwhelming majority (82.7% of beds, 86.6% of admissions and 80.9% of days of stay).

The numbers of beds and the admissions in chronic **psychiatric hospitals** were 46,934 and 106,798 in 1988, even though Law 180/1978, concerning mental health services, suggested closing all of these facilities³³. Nevertheless, there has been a significant decrease during the period analysed for psychiatric hospitals (-18.1% for beds, -4.1% for admissions and -14.2% for days of stay), and in 1988 they represented 11.1% of beds and 1.1% of admissions. However the decrease has occurred only in public hospitals, which now represent 61.2% of beds and only 36.1% of admissions.

Non-psychiatric hospitals include **general** and **specialized** hospitals; the general hospitals represent 91.2% of the admissions and 87.2% of the bed days of non-psychiatric hospitals in 1988. Private hospitals account for 16% of admissions to specialized hospitals, but 33.2% of bed days. This difference arises because the majority of private specialized hospitals are long stay.

Table 2.5 shows the mean lengths of stay and the occupancies of the non-psychiatric hospitals. The **mean length of stay** in non-psychiatric hospitals was 10.3 days in 1988, which is less than the standard of 11 laid down by the Law 595/1985. This is due

(33) The figures include neuropsychiatric hospitals. However the overwhelming majority are represented by the psychiatric hospitals.

Table 2.4

TREND OF BED CAPACITY AND ACTIVITY OF ITALIAN HOSPITALS

	1984		1986		1988	
	No.	%	No.	%	No.	%
<u>General + Specialised Hospitals</u>						
Beds	424,140	88.1	398,468	88.5	377,438	88.9
Admissions	9,665,796	98.9	9,444,692	98.9	9,425,413	98.9
Days of Stay	105,053,268	86.3	100,204,460	86.7	96,777,270	87.1
<u>Psychiatric Hospitals</u>						
Beds	57,273	11.9	51,909	11.5	46,934	11.1
Admissions	111,411	1.1	104,402	1.1	106,798	1.1
Days of Stay	16,665,976	13.7	15,342,374	13.3	14,298,690	12.9
<u>Total Hospitals</u>						
Beds	481,413	100.0	450,377	100.0	424,417	100.0
Admissions	9,777,207	100.0	9,549,094	100.0	9,432,211	100.0
Days of Stay	121,719,244	100.0	115,546,834	100.0	111,075,960	100.0
<u>Public Hospitals</u>						
Beds(*)	407,167	84.6	377,469	83.8	350,782	82.7
Admissions	8,557,771	87.5	8,305,100	87.0	8,257,595	86.6
Days of Stay	100,587,402	82.6	94,464,873	81.8	89,926,142	80.9
<u>Private Hospitals</u>						
Beds (**)	74,246	15.4	72,908	16.2	73,635	17.3
Admissions	1,219,436	12.5	1,243,994	13.0	1,274,616	13.4
Days of Stay	21,131,842	17.4	21,081,961	18.2	21,249,818	19.1

(*) Public hospitals include classified hospitals and public scientific institutes.

(**) Private hospitals include private scientific institutes.

Source: Istat.

to the contribution of public hospitals (9.9), since private hospitals have a longer length of stay (13.1). The converse situation is seen when occupancy is considered. Occupancy nationally is 70.2%, just inside the range of 70%-75% laid down by the Law; but the figure for private hospitals is 77.9%, while that for public hospitals is only 68.9%.

Table 2.5

TRENDS OF THE MAIN INDICATORS OF EFFICIENCY

	1984	1985	1986	1987	1988
<u>All Non-Psychiatric Hospitals</u>					
Mean Length of Stay	10.9	10.7	10.6	10.4	10.3
Occupancy	67.9%	67.9%	68.9%	69.0%	70.2%
<u>Public Hospitals(*)</u>					
Mean Length of Stay	10.5	10.3	10.2	10.0	9.9
Occupancy	66.6%	66.7%	67.6%	67.7%	68.9%
<u>Private Hospitals(**)</u>					
Mean Length of Stay	13.4	13.4	13.2	13.1	13.1
Occupancy	75.9%	75.8%	77.3	77.3%	77.9%
<u>All Hospitals</u>					
Mean Length of Stay	12.4	12.2	12.1	11.8	11.7
Occupancy	69.3%	69.1%	70.3%	70.3%	71.7%
<u>Public Hospitals (*)</u>					
Mean Length of Stay	11.8	11.5	11.4	11.1	10.9
Occupancy	67.7%	67.5%	68.6%	68.6%	70.2%
<u>Private Hospitals(**)</u>					
Mean Length of Stay	17.3	17.3	16.9	16.8	16.7
Occupancy	78.0%	77.5%	79.2%	79.0%	79.1%

(*) Public hospitals include classified hospitals and public scientific institutes.

(**) Private hospitals include private scientific institutes.

Source: Istat

During this period there is evidence of increasing efficiency of bed-use. Mean

lengths of stay decrease slightly, while occupancies increase slightly. However it is important to note that the decrease in mean length of stay in public hospitals could be affected by a shift to day care for minor illness. Day care patients are incorrectly included in figures for bed days, each day care patient being considered equivalent to one bed day.

Tables 2.6 and 2.7 show outflow and inflow of patients across the boundaries for macroareas in 1987.

The most significant movement is the flow of patients from southern areas to central and northern areas: 179,883 admissions which represent 6.1% of the total admissions among the southern population.

Table 2.6
CROSS-BOUNDARY OUTFLOW OF ADMISSIONS (1987)

Region of Admission	Region of Residence			
	North-West	North-East	Central	South
North-West	97.3%	0.7%	1.4%	2.2%
North-East	1.0%	98.3%	0.61%	0.6%
Central	1.3%	0.8%	97.3%	3.3%
South	0.5%	0.2%	0.7%	93.9%
Total	100.1%	100.0%	100.0%	100.0%

Source: DoH (Central Service for Health Planning)

Significant data on the geographical distribution and disaggregation for the four kinds of hospitals mentioned above are available only for 1987. Beds per 1000 inhabitants

at the national level are 7.6 (Table 2.8), still higher than the standard of 7.0 laid down by Law 595/1985³⁴. This figure is the result of a heterogeneous geographical situation, illustrated by a variation from 6.4 in the southern area to 9.9 in the north-eastern area.

Table 2.7
CROSS BOUNDARY INFLOW OF ADMISSIONS (1987)

Region of Residence	Region of Admission			
	North-West	North-East	Central	South
North-West	95.6%	1.9%	1.3%	0.4%
North-East	0.4%	95.6%	0.4%	0.1%
Central	1.3%	1.0%	94.0%	0.6%
South	2.7%	1.5%	4.3%	99.0%
Total	100.0%	100.0%	100.0%	100.0%

Source: DoH (Central Service for Health Planning)

The number of admissions per 1,000 inhabitants is 171.9, which is slightly higher than the standard of 160 laid down by the law, but the geographical variation is less than the variation for the number of beds per 1,000 inhabitants³⁴.

Graph 2.2 shows broad regional values of mean length of stay and occupancy; the diagram has been subdivided in quadrants by using the standard values of Law 595/1985.

(34) The law lays down a standard of 6.5 beds per 1000 inhabitants. However, this includes only 50% of private beds because they are supposed to be complementary to those of public hospitals. In order to make realistic comparisons with actual figures an element has been added to the standard of 6.5, obtained by applying the standard rate of 6.5 to half the percentage of beds in private hospitals (16%). Mathematically: $X = (0.16 \times 0.5) \times 6.5 = 0.5$.

Table 2.8**GEOGRAPHICAL DISTRIBUTION OF BEDS AND ADMISSION (1987)**

	Beds per 1000 Inhabitants	Index National Base = 100	Admissions per 1000 Inhabitants	Index National Base = 100
North-West	7.71	101.3	182.2	106.0
North-East	9.93	130.5	204.1	118.7
Central	8.04	105.7	177.2	103.1
South	6.41	84.2	149.1	86.7
National	7.61	100.0	171.9	100.0

Source: DoH (Central Service for Health Planning)

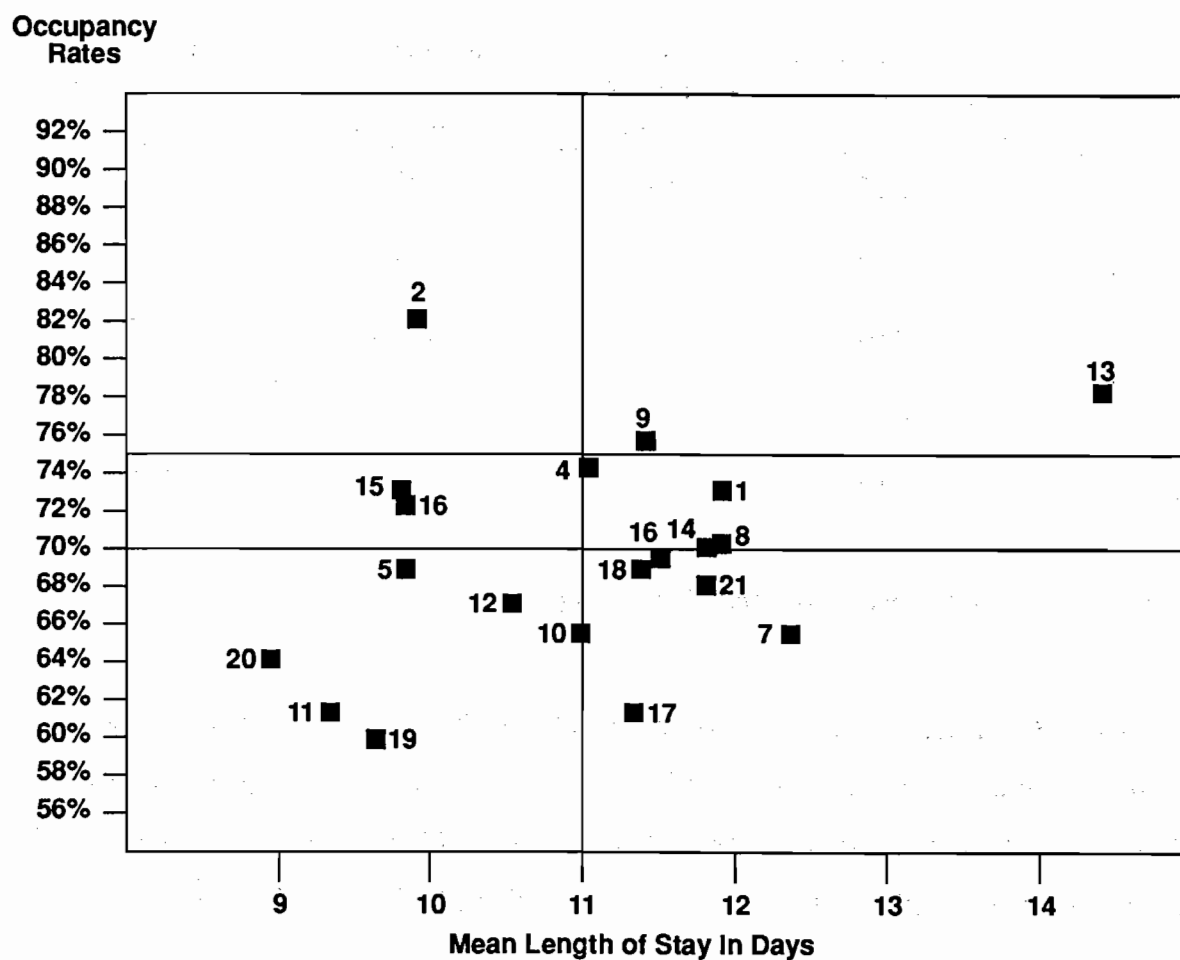
Scientific Institutes (2.4% of the total number of beds and 5% of admissions) and **Classified Hospitals** (2.5% of beds and 2.6% of admissions) are a minority throughout the country, so the figures relating to them will not be discussed. The most interesting comparison is between private hospitals and public hospitals managed by LHUs.

The percentage of private beds is higher in central (18.7% of the total) and southern (18.5%) areas, and is negligible in the north-eastern area (8.4%). All over the country private hospitals have occupancies which are significantly higher than those of public hospitals, but mean lengths of stay which are twice as long. This is also seen when the figures are divided among the main specialties (Table 2.9).

There are two connected reasons for this:

1. the system of payment per bed day, which stimulates the private hospitals to increase the length of stay;

GRAPH 2.2
EFFICIENCY OF HOSPITAL SERVICES (1987)



■ Regions

- | | |
|-------------------------|---------------|
| 1 PIEDMONT | 12 MARCHE |
| 2 VAL D'AOSTA | 13 LAZIO |
| 3 LIGURIA | 14 ABRUZZO |
| 4 LOMBARDY | 15 MOLISE |
| 5 P.A. BOLZANO | 16 CAMPANIA |
| 6 P.A. TRENT | 17 PUGLIA |
| 7 VENETO | 18 BASILICATA |
| 8 FRIULI VENEZIA GIULIA | 19 CALABRIA |
| 9 EMILIA-ROMAGNA | 20 SICILY |
| 10 TUSCANY | 21 SARDINIA |
| 11 UMBRIA | |

Source: DoH (Central Service for Health Planning)

Table 2.9

DISTRIBUTION OF PUBLIC AND PRIVATE HOSPITALS BY SPECIALTY (1987)

Specialty	% of Beds		% of Admissions		Mean Length of Stay		% Occupancy Rates	
	Public	Private	Public	Private	Public	Private	Public	Private
General Medicine	19.4	13.0	19.0	16.6	11.8	17.7	75.1	97.5
Surgery	15.9	13.0	16.2	27.1	10.0	9.4	65.9	84.9
Obstetrics and Gyn.	8.5	6.0	13.1	14.6	5.8	6.8	58.5	71.6
Paediatrics	5.5	0.4	5.9	0.4	5.1	8.4	35.9	37.5
Orthopaedics	8.6	5.8	11.8	11.7	8.0	11.1	71.6	96.8
Others	42.1	61.8	33.9	29.6	-	-	-	-
Total	100.0	100.0	99.9	100.0	10.3	19.9	66.7	85.8

Note: Public hospitals considered are only those dependent on LHUs.

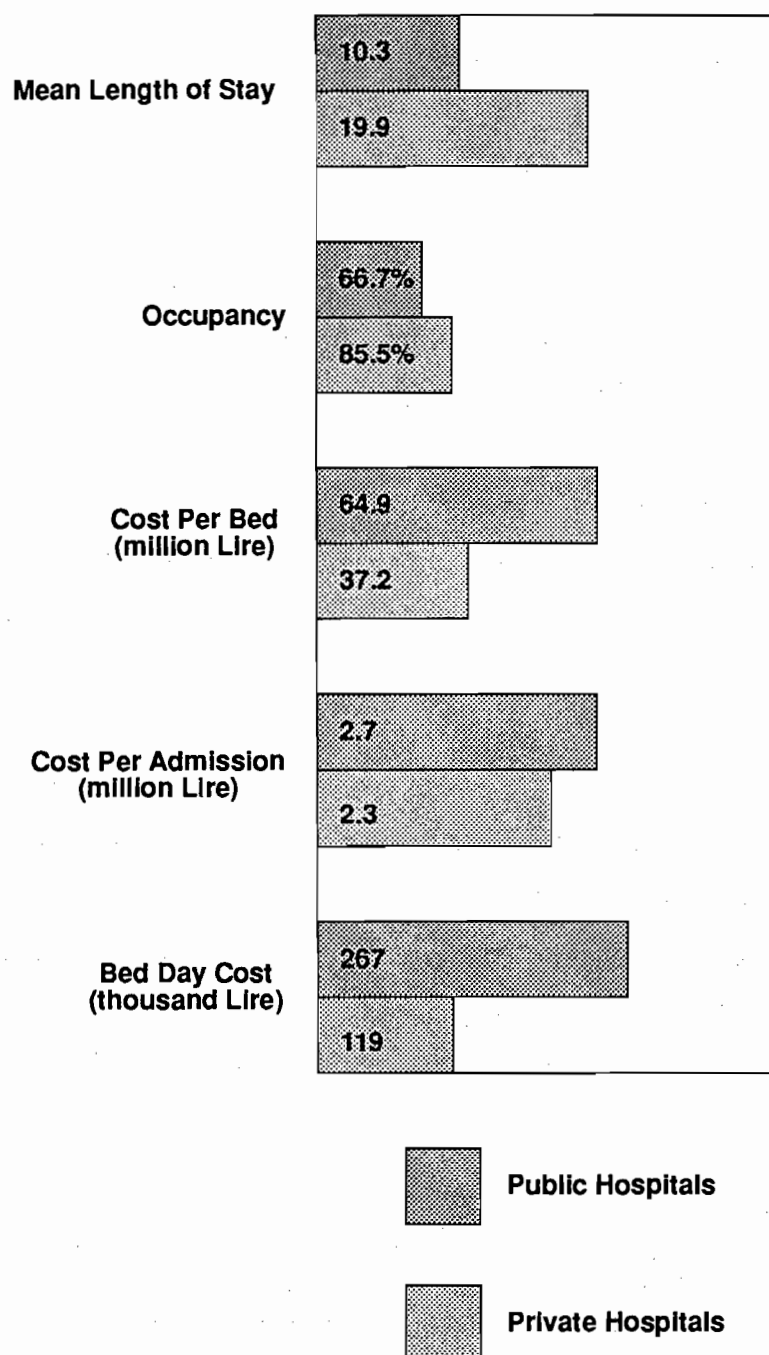
Source: DoH (Central Service for Health Planning).

2. the strong and increasing influence of the long stay wards inside the private hospitals, which are more profitable because of the system of payment.

It is interesting to compare the performance of private and public hospitals by using economic indicators (Graph 2.3). Private hospitals are often supposed to be more "efficient" than public hospitals in Italy, because their bed day cost is less than half that in public hospitals. However the most significant indicator to compare from the NHS point of view (as a purchaser of the service) is the cost per admission. This figure is slightly higher for the public hospitals, but this difference can be largely explained by the presence of emergency services and the greater complexity of cases treated, as the figures shown above and the cost per bed (which is markedly higher for public hospitals) indirectly confirm.

In general, the performance of the Italian hospital system can be considered acceptable in terms of structure, activity and efficiency. Mean lengths of stay and occupancies are good at regional level, however the distribution of facilities still exhibits inequality; consequently movement of patients across the regional boundaries is considerable, particularly from the poorer southern regions to the wealthier central and northern regions. The role of private hospitals in relation to public hospitals is, broadly, more complementary than competitive. Most of the private hospitals are situated in regions which have been historically under-supplied with public hospitals and are increasingly specializing in long stay specialties. Throughout the country, and in each specialty, their performance is very different from public hospitals. Higher occupancies are consistently related to longer lengths of stay. Both these factors reflect the system of payment which is crude and inefficient.

GRAPH 2.3
COMPARISON BETWEEN PUBLIC AND PRIVATE HOSPITALS (1987)



Source: Ce.R.G.A.S. and DoH (Central Service for Health Planning)

3. FINANCIAL MANAGEMENT

3.1 Income

Graph 3.1 shows sources of NHS income during the period 1984-1989³⁵. There are three sources: health contributions, local income and general taxation.

3.1.1 Health Contributions

Health Contributions are still an important source of funding, even though the Reform Law N.833 advocated their abolition. Contributions come mainly from employees in the public and private sectors and from self-employed workers.

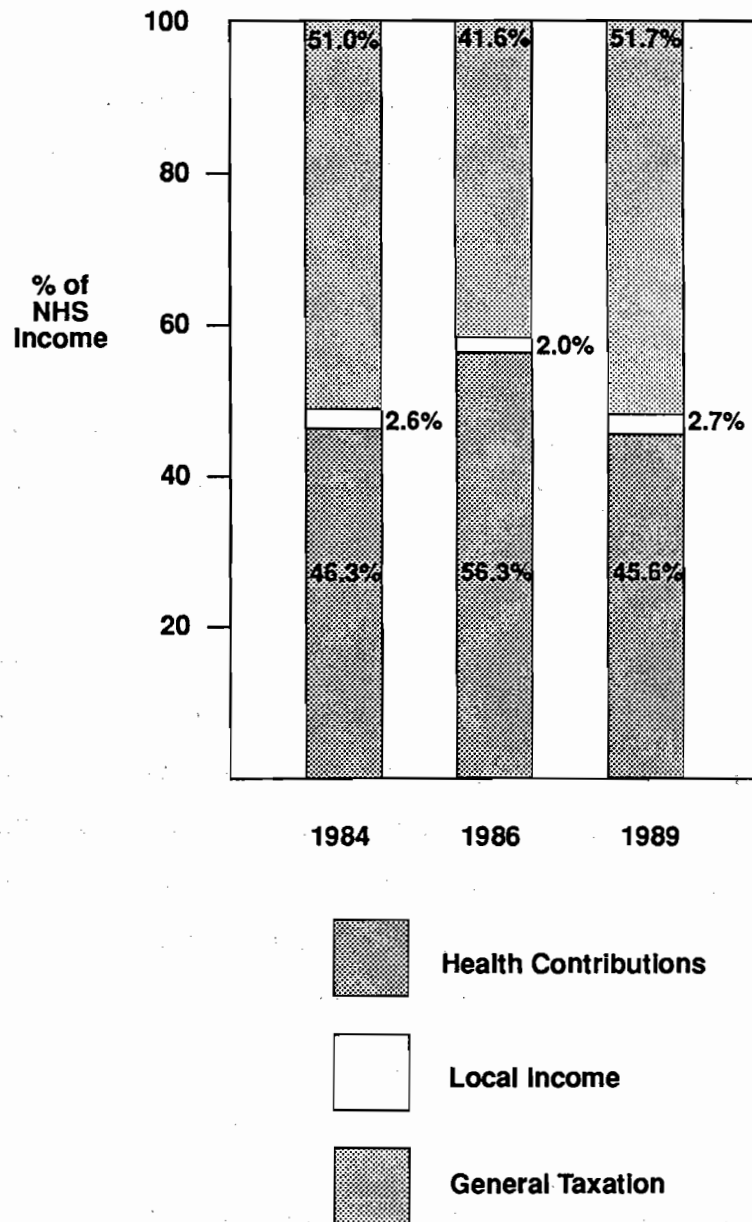
For employees the contribution is 10.5% of gross income (0.9% of which is charged to the employee and the remaining 9.6% to the employer) up to 40 million lire (about £18,000) per annum, and 4.2% thereafter (0.4% of which is charged to the employee and the remaining 3.8% to the employer).

In practice the actual contributions can differ considerably from the theoretical contributions. The Government is able to subsidise companies in order to decrease labour costs, so as to alleviate problems arising from the current economic situation. The amount of money saved by companies through this "discount" continually diminished during the period under review (from 50.2% of the employees' contribution in 1984 to 21.8% in 1989), mainly because of an improving economic situation³⁶. Consequently the proportion of total contributions arising from employed workers increased significantly during the

(35) 1984-1989 has been the period chosen for the analysis of all financial figures. The previous period (1978-1984) can be considered a transitional period from the former to the current system, in which the information system has had a sort of "black out", particularly for expenditure figures.

(36) Another reason for this decrease is that the Government has stimulated the recruitment of young unemployed, by providing (since 1984) substantial direct "discounts" in contributions if companies employ people under thirty. This is known as the "training-labour contract".

GRAPH 3.1
SOURCES OF NHS INCOME



Source: I.S.I.S.

period, from 54.3% in 1984 to 65.6% in 1989.

For the self-employed category, the so-called "health tax", introduced at the beginning of the 1980s is 5% of income up to 40 million lire and 4.2% thereafter. There was a sizeable reduction in the proportion of total contributions that the health tax represented, falling from 16.2% in 1984 to 12.5% in 1989.

The proportion of public health expenditure made up by contributions fluctuated considerably during the period 1984-1989, but at the end of the period had returned to the original value of 46%.

3.1.2 Local Income

Local Income includes the "ticket" charges levied on drugs, diagnostic procedures and specialist visits, and services charged by the LHUs, the contribution of which is at present very limited.

As regards the "ticket" charges, the figures in Graph 3.1 include only those related to diagnostic procedures and specialist visits, which are directly collected by the LHUs and thus accounted in their balance sheets. Prescription charges for drugs, which are more important as an income, are collected by the pharmacies and are not included in the LHUs' accounting system³⁷. For this reason the contribution of this source to the expenditure of the NHS seems to be negligible. Its incidence has never been more than 2.7% (1989) whereas if it included the pharmaceutical "ticket" it would rise up to 5% for certain years (1984, 1986, and 1989).

(37) Actually the accountancy office of the DoH has often reminded the Regions that LHUs balance sheets should formally take account of the pharmaceutical "ticket" in the income. That could be very easy to do in practice; in fact pharmacies declare the total amount of "tickets" to the LHUs every month for the reimbursement of the net expenditure. However LHUs still hardly ever do it, because public administration accountancy forbids them to keep an income which is not directly drawn. Therefore the pharmaceutical expenditure accounted can be considered the net one (see also Section 3.3).

3.1.3 General Taxation

General Taxation is the third source of income. It is used for:

- i) integrating contributions in determining the budget allocation for the NHS, the National Health Fund (see next Section);
- ii) funding the deficits that Regions run up every year because of the underestimate of the National Health Fund; this will be discussed in the next Section. However it should be noted that deficits can be very significant (for instance, in 1988 they represented 13.8% of the total revenue).

The proportion of total public health expenditure arising from general taxation also fluctuated markedly, but at the end of the period it had returned to approximately 52%.

3.1.4 Contributions vs Taxation

Having noted the usual dilemma of funding from general taxation and contributions for Italy (Rey, 1986), it is worth underlining some of the strengthes and weaknesses of the two fiscal tools. As mentioned above, the Reform Law N.833 advocated gradually eliminating contributions and using general taxation as the sole source of funding of the NHS. The logic underlying this was that a contribution paid by certain categories of the population for a public service delivered to all the population is theoretically inequitable³⁸. Overall, the most important strength of general taxation is to make possible at the central level an allocation of public expenditure between the different sectors (health care, transport, social insurance, etc.) which is not necessarily linked with related incomes; this "dislinkage" theoretically allows the implementation of a more flexible public expenditure policy.

(38) Actually inequity has been reduced by the introduction of the "health tax", even though evasion by the self-employed is generally held to be very frequent in Italy.

Other more specific advantages of general taxation are:

1. rates which can be progressive, while those of contributions are necessarily proportional (for administration and accountability issues);
2. the possibility of diminishing the contribution of labour costs to export prices³⁹.

Conversely it is necessary to point out that contributions are politically more acceptable than general taxation for two main reasons:

1. taxpayers can equate the cost of contributions with the benefits received from public expenditure;
2. employees feel that employers pay the contribution for them (which may be fiscal illusion)

3.2 Allocation of Financial Resources

3.2.1 National Health Fund

The budget assigned to the NHS is called the **National Health Fund (NHF)**. The total amount of the NHF is determined yearly by the **Financial Law**, which defines the Government budget.

The NHF is divided into two funds, one for **current expenditure** and one for **capital expenditure** (investments in assets and equipment and machinery); the former is managed by the Treasury, the latter by the Ministry of the Budget.

The Reform Law proposes the gradual elimination of inequalities as the main aim which the criteria of allocation of financial resources among the regions (which are

(39) In fact, if it is decided to shift contributions in indirect taxes (typically V.A.T.), these can be reimbursed for goods exported. On the contrary contributions are necessarily included in labour cost and therefore increase export prices.

determined by the DoH) should work towards.

Since 1987 the fund for the current account has been divided into four budgets:

1. **Collective Prevention**, which comprises public health and veterinary care, and represents 7% of the fund. Allocating this budget is based mainly on regional populations.
2. **Non Hospital Care** represents 40% of the fund. This comprises primary care, pharmacy services, specialist care (visits and pathology and radiology tests), rehabilitation and spas. The main criterion for allocating this budget is the regional population weighted for age structure and adjusted by regional Standardized Mortality Ratios (SMRs). However the contribution of the SMRs to the weighted value is only 5% of the deviation from the national value⁴⁰. The weights of the three age bands - children (0-11), adults (12-59) and elderly people (>60) - are related to the utilization of services and consequently vary from one area of provision to another.
3. **Hospital Care** represents 48 per cent of the fund. The criterion for allocating this budget is the same as for non hospital care; the only important difference is adjustment for cross-boundary flow between regions.⁴¹
4. **Administration**, comprising all the costs relating to the political and managerial functions of the LHUs, represents 5% of the fund. This budget is allocated in

(40) In practice it means that, if two regions' SMRs (expressed in number index with the national value equivalent 1) are for example 1.02 and 0.98, the two regional weighted populations will be multiplied by 1.001 and 0.998.

(41) The regional net balance of admissions between inflows and outflows (negative or positive) is costed by multiplying the total number by a specialty crude cost. In 1987 the values were 1.9 million lire (around £860) per admission for the "basic" specialties (general medicine, surgery, obstetrics and gynaecology, paediatrics), 3.8 for the "average" specialties and 9.5 for the "high" specialties (for example plastic surgery).

proportion to the sum of the other three budgets; the hypothesis underlying this criterion is that administrative expenditure is proportional to the total amount of expenditure managed for health services.

3.2.2 Regional Health Funds

The total of the regional allocations for each budget determines the theoretical **Regional Health Funds (RHF)**s. The allocations for budgets are a tool for quantifying RHF and are at most flexible targets; they are not binding on the Regions. The final operation for determining the actual RHF consists of reconciling the theoretical RHF obtained from the model with actual patterns of expenditure.

From a technical point of view the model is acceptable and consistent with the aim of the Reform Law. However, there are concerns regarding the quality and meaning of the parameters used in the model (weights and percentages); a good example in this sense is the way SMR have been utilized.

More generally, the allocation of current account calls for more coordination with the allocation of capital account in the present system. A more equitable distribution of financial revenue must be linked with the regional availability of public organisations providing services, particularly for poor regions, otherwise the surplus of money can be spent only in purchase of private services and goods.

However discussion about technical aspects of the model bears little relationship to its practical impact. Although the financial system described above is a "cash-limited" budgetary system, what happens in practice is quite different and calls for explanation.

First of all it is necessary to emphasise that deciding a figure for the NHF and agreeing its allocation is always delayed; obviously such a problem undermines the budgetary system because it gives rise to uncertainty at regional level about the amount of money available at the beginning of each year.

Moreover, the requirement of the NHF has consistently been underfunded (see the discussion of Table 3.1 above). In fact the current account budget is systematically set at less than expenditure of the previous year, with no account taken of inflation and the rising trend of expenditure experienced in most countries. This is the result of the political strategy of Italian Governments, which aim to give the impression that they are trying to contain public expenditure through the Financial Law, both for domestic and international reasons, even though the targets are hardly feasible and their policies during the year are often inconsistent with this goal.

In the case of health care, cash limits have lost credibility at the local level as a system of control. Typically Regions start disputing the adequacy of financing in the early months of each year and overspend their budget. Eventually the Government has always paid off these debts by passing special laws⁴².

The final result of this political negotiation has been to benefit Regions which have overspent on purpose and to penalise Regions which tried to keep spending in line with their budget. No assessment of the real reasons for overspending has been undertaken and the most successful regional strategy has been to maximise expenditure.

The data confirm that regional financial behaviour has been very varied. The proportion of the deficit on the fund varies between the Regions but all show an increasing trend (from 7.1% to 16.4% in 1986 and from 7.4% to 29.5% in 1989).

The southern area (the poorest one, which should consequently benefit more from the model of allocation of financial resources) has the highest proportion of deficits on its funds (Graph 3.2). This is the area which is characterized by dramatically high pharmaceutical and contracted specialist per capita expenditure, the types of expenditure most open to abuse (see Sections 2.1.2 and 2.2.2). Deficits do not, therefore, necessarily result from the scarcity of financial resources, but may be due to "overspending" on certain

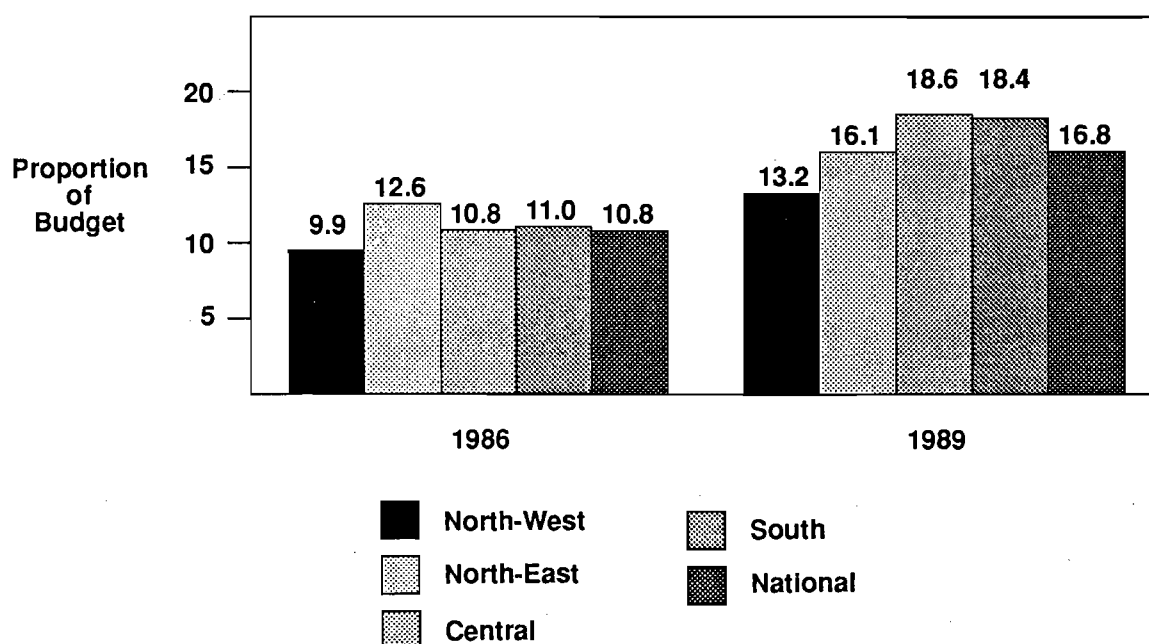
(42) In the period analysed these laws were passed almost every years (Laws N.733/1984, N.103/1985, N.456/1987, N.262/1989).

services such as drugs and specialist visits.

Once the RHF's have been defined, each region can decide how to allocate the financial resources among the LHUs (see Section 1.1.2). In most of the Regions criteria for allocating financial resources among LHUs should take account of levels of activity and should seek to enhance efficiency (as well as a general concept of equity), particularly for hospital services (Fattore and Garattini, 1989). In fact, given the large number of LHUs, there are many small LHUs which cannot deliver all the services needed by the local population and consequently there is considerable cross-boundary flow⁴³.

In practice most of the Regions simply base their allocations on past expenditure. Figure 3.1 summarizes the stages of money flow from the central to the local level.

GRAPH 3.2
PROPORTION OF DEFICITS ON BUDGETS

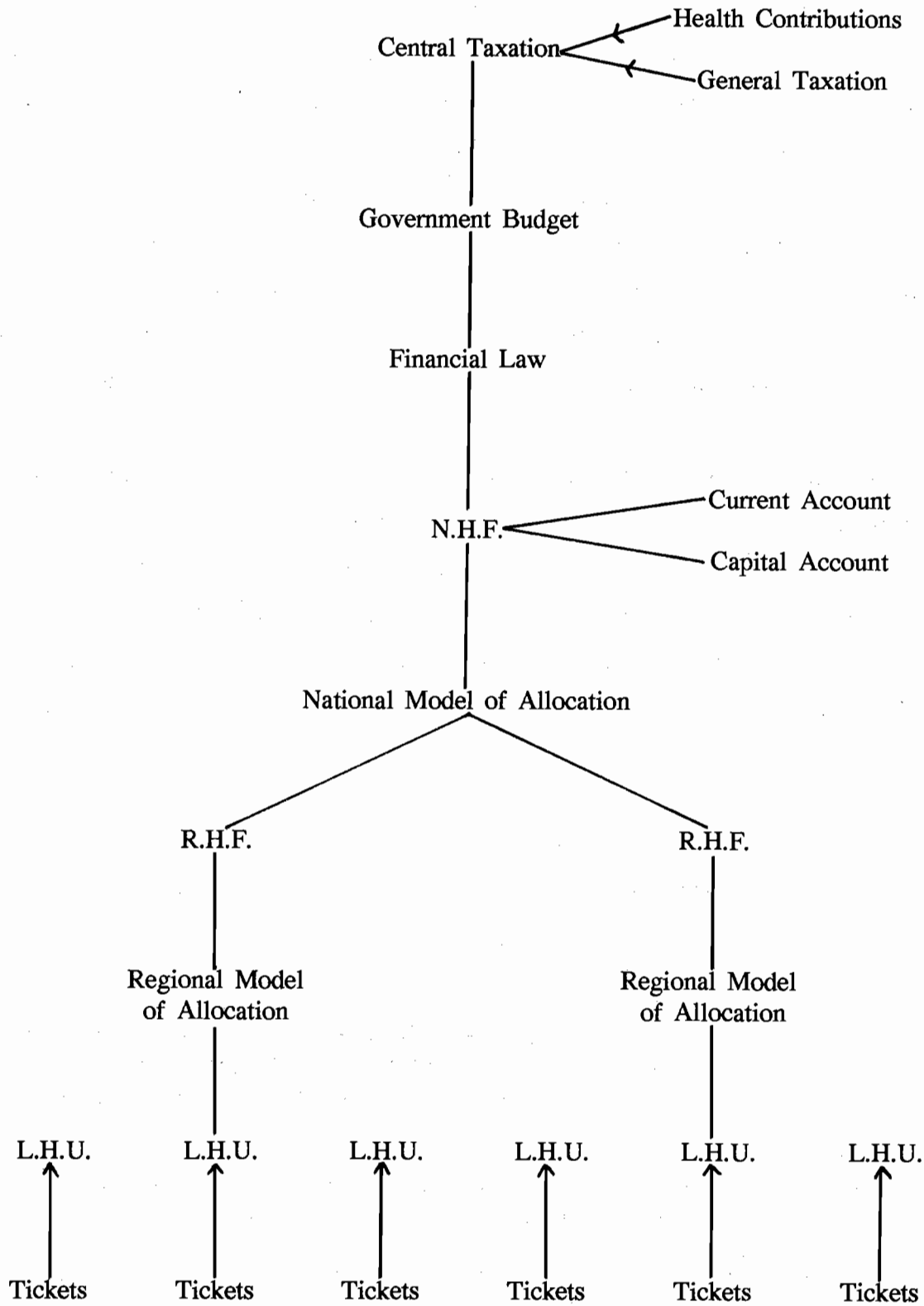


Source: DoH (Central Service for Health Planning).

(43) A system for reimbursing movement of patients between LHUs could be envisaged. But at the moment is considered to be impracticable, given the high level of cross-boundary flows and the burden such a system would place on the LHU's administrative structure.

Figure 3.1

FUNDING OF THE ITALIAN NHS



3.2.3 The Capital Account

The capital account is divided into three different funds: **maintenance**, **investment** in new capital items and the **redevelopment** of existing assets for alternative use. The number of beds in public hospitals is the criterion used for allocating the share for maintenance (37.5% of the total fund); in the Regions where there are more beds than the standard of 6 per 1000 inhabitants (see Section 2.3), the number of beds is reduced by 20% for this calculation. The share for investment (36.5% of the total fund) is allocated on the grounds of population size. The share for redevelopment (the remaining 26% of the total fund) is further divided into two different funds; the former is allocated on the basis of the number of beds in any unit which is going to be redeveloped for alternative use, the latter is allocated with reference to the criterion used for maintenance.

The criteria used for allocating the capital account seem to be inconsistent with those utilized for the current account, which are inspired by the reequilibrium of expenditure. In fact only the amount for investment takes account of population⁴⁴, whereas the allocation of the other two funds is linked with the present structural position. Allocation of the capital account should also take account of equipment and machinery, the distribution of which seems to be even more unbalanced than that of other capital assets, such as land and buildings⁴⁵.

Table 3.1 shows the increase of capital account budget and of revenue in the period 1984-1989⁴⁶. Although the proportion of the capital account on total expenditure has significantly increased during the period (from 2.0% in 1984 to 2.8% in 1989, reaching

(44) It is interesting to note the inconsistency between the parameters used for the two accounts. The major criterion used for the current account is the population weighted per age bands, while for capital account it is the total population.

(45) Actually very little is known about it, but the few studies available show a high disequilibrium (for instance in 1982 there was a CT scanner every 350,000 inhabitants in North Italy, one every 600,000 inhabitants in South Italy).

(46) The reason why capital account budget is compared to revenue expenditure is due to the problem of deficit for current account. On the contrary this problem does not exist for capital account because no formal deficit is run up.

Table 3.1
PROPORTION OF CAPITAL ACCOUNT ON REVENUE (BILLION LIRE)

	1984	1985	1986	1987	1988	1989
Revenue (1)	37,474	42,108	45,064	53,864	61,820	67,172
Capital Account Fund (2)	750	1,200	1,610	1,680	1,800	1,917
(2)/(1)	2.0%	2.8%	3.6%	3.1%	2.9%	2.9%

Source: I.S.I.S.

an all time high of 3.6% in 1986), it is still insufficient for the needs of the NHS⁴⁷.

Given the scarcity of resources for capital investment, the Government has decided to compensate for the lack of investment during the post-reform period by a Decennial Plan passed in 1988 which foresees a financial commitment of 30,000 billion lire (approximately £13.6 million). The money will be distributed to individual projects by an Evaluation Committee of the DoH. Its task is to appraise all the feasibility studies presented by the LHUs and to accept those which are consistent with the objectives of regional reequilibrium and rationalization of the networks of hospitals, outpatient clinics, day-hospitals and nursing homes for elderly and disabled people.

With regard to **medical equipment**, most of the LHUs bypassed the scarcity of finance and the consequent deterioration of the equipment in two ways:

- 1) through the purchase of small items on current account;
- 2) through the so called "use commodatum", that is the free loan of medical equipment by the commercial companies. The companies derive a benefit from this operation

(47) However it is important to underline that Regions are also allowed to finance investments in health care with money coming from other sources (for example the overall regional budget, the budget of the Ministries of Education and of Public Works).

through the sale of disposable items and through maintenance contracts at a high price that more than compensates for the cost of the machinery.

Consequently no deficit is registered for the capital account related to medical equipment, mainly because the problem of underestimating is "discharged" on the revenue account.

The inadequacies of capital funding are related to the weakness of hierarchical relationships between the regional tiers of the NHS. A system in which income is centralized and expenditure is decentralized requires clear accountability to the centre by the periphery.

The Reform Project proposes the elimination of the NHF and its substitution by the **Interregional Health Fund (IHF)**, to be approved annually by 31st October for the coming year. In practice it means that Regions will receive a fixed amount of money, the amount of which they will know well in advance. Any savings will be reinvested in regional health care (land and buildings, equipment and instruments and scientific research); any deficits will be the responsibility of regional authorities and will be funded through other funds coming from the regional authorities' budget or new local taxes⁴⁸.

Theoretically this system should be not only more effective, but also more flexible and responsive to local needs. As the IHF would guarantee provision of the minimum set of services laid down by the NHS, local taxation could be used for "additional" services considered important for the local population.

This innovation is not necessarily inconsistent with the aim of the Reform Law to overcome regional inequalities (see Section 1.1.1). In fact the Law mentions as a main

(48) This possibility is consistent with that laid down in the Reform Bill Project concerning local autonomy. In fact local authorities have no powers to impose taxes at the moment.

target minimum levels of services which have to be guaranteed to the citizens⁴⁹.

However the crux of the matter could lie once again in the total amount of money assigned to the IHF. Regions could continue to dispute with the DoH in the future if the Government continues to underestimate the health care budget. For this reason the IHF should be determined separately from the Financial Law, which is dominated by the current economic situation. As a possible alternative the DoH could determine the budget directly for a period of three years in coordination with the NHP.

3.3 Expenditure

3.3.1 Overall Expenditure

Table 3.2 shows the trend of public and private current expenditure on health care for the period 1984-1989.

Public current expenditure in Italy increased by 80% during the period in absolute terms, and by 30% when inflation is taken into account (using the implicit deflator of GDP)⁵⁰. The percentage of GDP spent on public health care has stayed nearly steady during the period (from 5.2% in 1984 to 5.5% in 1989) (Graph 3.3).

Private expenditure, which includes prescription charges, doubled during the period in current values. The main components of this expenditure are estimated to be private specialist consultations (34.8% of total private expenditure in 1989), admissions to private

(49) In fact the proposed IHF is not consistent with the general objective of equity: wealthier Regions will be very likely to deliver more services because they will be able to finance them. On the other hand it is necessary to remember that in most of the developed countries levels of demand are proportional to income and that movement of patients across regional boundaries is already a significant phenomenon in Italy (see Section 2.3.3).

(50) Unfortunately there is not yet in Italy a significant deflator for the health care sector. The only one available, calculated by Istat, is commonly considered unreliable and has a trend very similar to the implicit deflator of GDP.

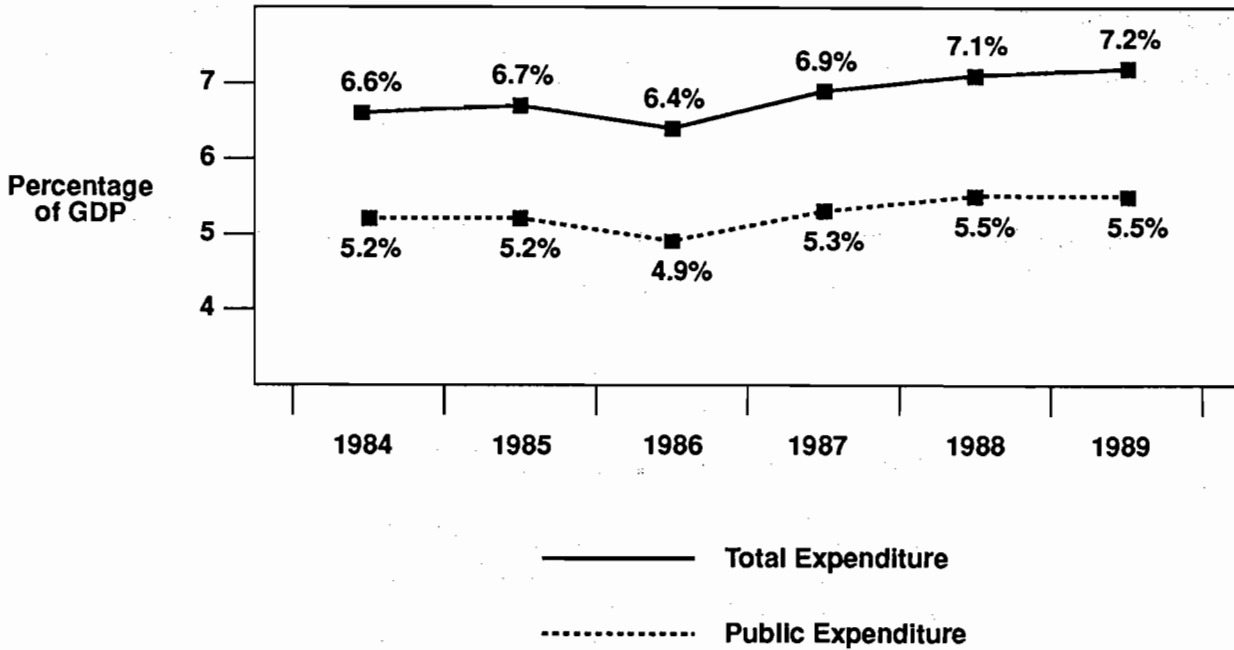
Table 3.2

**TREND OF CURRENT EXPENDITURE ON HEALTH CARE IN CURRENT
AND DEFLATED VALUES; % ON G.D.P. (BILLION LIRE)**

	1984	1985	1986	1987	1988	1989
Public Current Expend (1) Index Number	37,474 100.0	42,108 112.4	45,064 120.3	53,864 143.7	61,820 165.0	67,172 179.2
Public Current Expend Deflated Index Number	37,474 100.0	38,667 103.2	38,450 102.6	43,404 115.8	46,868 125.1	47,911 200.4
Private Expenditure Index Number	10,592 100.0	12,439 117.4	14,814 139.9	15,764 148.8	17,893 168.9	21,227 200.4
Prescription Charges for Drugs	731	931	1,348	813	1,160	1,756
Net Private Expend (2) Index Number	9,861 100.0	11,508 116.7	13,466 136.6	14,951 151.6	16,733 169.7	19,471 197.5
Net Private Expend Deflated Index Number	9,861 100.0	10,568 107.2	11,490 116.5	12,048 122.2	12,686 128.6	13,888 140.8
(1)/[(1) + (2)]	79.2%	78.5%	77.0%	78.3%	78.7%	77.5%
(2)/[(1) + (2)]	20.8%	21.5%	23.0%	21.7%	21.3%	22.5%

Source: I.S.I.S.

GRAPH 3.3
HEALTH CARE EXPENDITURE AS A PROPORTION OF GDP



Source: I.S.I.S.

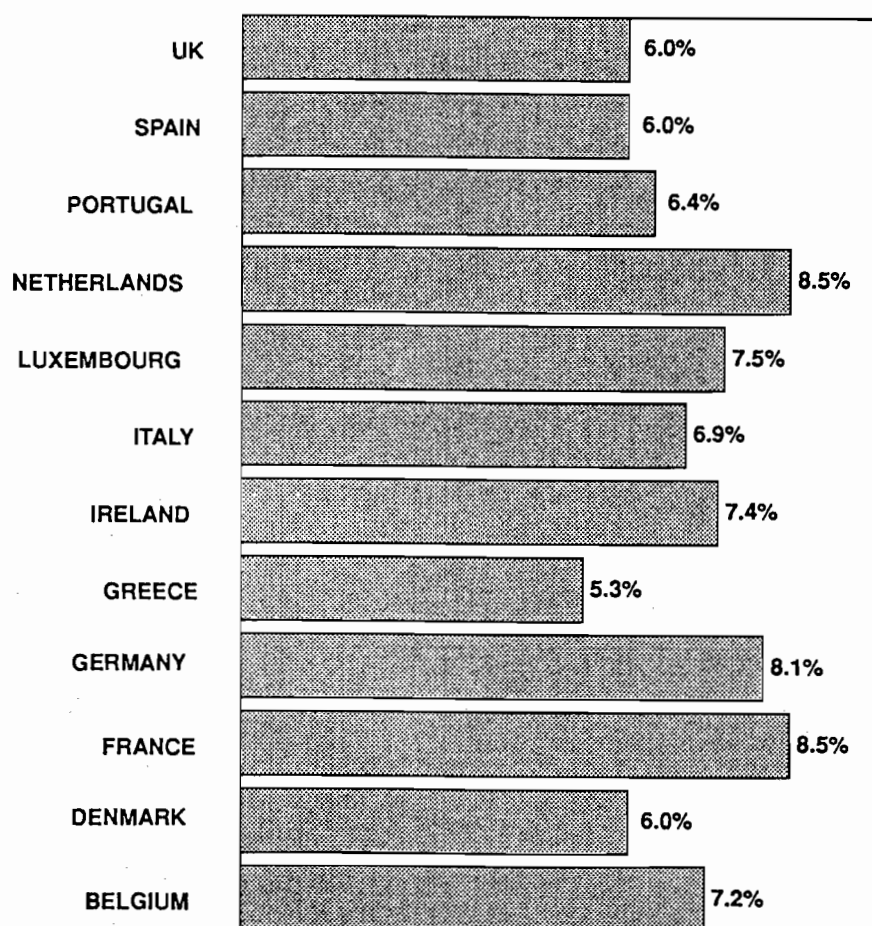
hospitals outside the NHS (28.5%) and the private purchase of drugs (14.2%), while contributions to company funds⁵¹ and private insurance overall are only 8% of the total.

If the estimates of prescription charges for drugs (the most important in terms of contribution) are subtracted from private expenditure, the trend of 'net private expenditure' (ie private expenditure on private goods and services) slightly decreases and the rise, adjusted for inflation, is 40%. Therefore the proportion of private expenditure against total expenditure (excluding prescription charges for drugs) slightly increases in the period (from 20.8% in 1984 to 22.5% in 1989), but the overwhelming share of the total expenditure is still within the NHS (from 79.2% in 1984 to 77.5% in 1989).

(51) Some large firms have welfare funds to which employees contribute; usually they pay for single rooms in private hospitals and enable patients to have their own choice of surgeon.

Total health care expenditure as a percentage of GDP has increased steadily during the period (from 6.6% in 1984 to 7.2% in 1989) (Graph 3.3). In comparison with other countries of the European Community (EC) (Graph 3.4) and of the Organisation for Economic Co-operation and Development (OECD), the proportion of GDP in relation to total health care expenditure⁵² in Italy is slightly below the mean of both groups of countries, even though the trend of expenditure on health care is a little higher (Table 3.3).

GRAPH 3.4
PROPORTION OF HEALTH CARE EXPENDITURE ON GDP FOR
EEC COUNTRIES (1987)



Source: O.E.C.D.

(52) Only the data for total expenditure has been included because the combination of public and private expenditure is strongly influenced by the different institutional frameworks of the national system.

Table 3.3

**TREND OF TOTAL EXPENDITURE IN HEALTH CARE AND PROPORTION ON
G.N.P. IN E.E.C. AND O.E.C.D. COUNTRIES**

	% of G.D.P.					Health Expenditure Index (1984=100)				
	1984	1985	1986	1987	1988	1984	1985	1986	1987	1988
Belgium	7.2	7.2	7.2	7.2	7.2	100.0	107.1	112.8	118.7	125.9
Denmark	6.4	6.2	6.0	6.0	6.0	100.0	107.3	110.6	115.1	121.6
France	8.5	8.5	8.5	8.5	8.5	100.0	107.1	116.1	121.6	128.8
Germany	8.1	8.2	8.1	8.1	8.1	100.0	105.2	110.3	113.9	125.9
Greece	4.5	4.9	5.3	5.3	5.3	100.0	129.9	171.4	194.4	228.8
Ireland	8.0	8.0	7.8	7.4	7.4	100.0	106.2	111.5	113.1	125.9
Italy	6.6	6.7	6.4	6.9	6.9	100.0	113.4	124.4	145.1	165.6
Luxembourg	6.5	6.6	6.8	7.5	7.5	100.0	108.2	116.2	129.7	151.1
Netherlands	8.3	8.2	8.3	8.5	8.5	100.0	103.0	107.1	109.6	125.9
Portugal	6.3	7.0	6.6	6.4	6.4	100.0	139.4	165.6	189.0	218.8
Spain	6.0	6.0	6.1	6.0	6.0	100.0	111.5	128.5	142.6	165.6
UK	6.2	6.0	6.0	6.0	6.0	100.0	107.3	115.1	125.9	142.6
EEC	6.9	7.0	6.9	7.0	7.0	100.0	112.1	124.1	134.9	151.1
USA	10.4	10.6	10.9	11.2	11.2	100.0	107.9	117.3	128.8	142.6
OECD	7.0	7.1	7.3	7.4	7.4	100.0	112.5	126.2	139.7	151.1

Note: O.E.C.D. includes, in addition to E.E.C. countries and USA, Australia, Austria, Canada, Finland, Iceland, Japan, New Zealand, Norway, Sweden and Switzerland.

Source: O.E.C.D.

In Italy, as in other publicly funded system, expenditure on health care is less than in those countries without a public funded health service. This may be because they operate within a pre-determined budget and have more central methods for controlling expenditure (this second reason is much more relevant to the Italian NHS). The failure of financial management by the Italian NHS is most significant in determining the distribution of resources at local level, rather than in affecting the total amount of expenditure.

It is important to underline that all the figures shown in this report, and in the other publications concerning the Italian NHS, come from the yearly reports of the LHUs, and not from the balance sheets formally approved by the institutional agencies of the LHUs⁵³; it appears that the figures from the second source can be significantly higher because only part of the deficit is declared in the first report⁵⁴. It is, therefore, possible to speak about a "concealed deficit" in the NHS which becomes visible only when the Government enacts legislation to pay off the Region's debts (see Section 3.2.2 above).

3.3.2 Public and Private Expenditure

Before moving to more detailed expenditure analysis, it is interesting to note the scheme of Table 3.4, where public and private expenditure in 1988 is broken down according to two variables: provision and financing. The four quadrants show the different combinations of the public-private relationship in the Italian health care system.

The first quadrant (upper left) shows expenditure financed by the NHS and provided

-
- (53) It is hard to obtain figures from the second source for two reasons: 1) LHUs approve them only after a considerable delay (2-3 years), because they wait for the special laws mentioned in the previous section to balance the budget (every formal public budget has to be balanced in Italy); 2) they are not published in official publications.
- (54) This seems to be due mainly to contracts with private companies for the purchase of goods and services, which are posted with amounts lower than actual figures. However some years there is also a long delay in the renewal of the national labour contract of the NHS; consequently rises can have retroactive effects.

Table 3.4

PUBLIC/PRIVATE MIX IN THE ITALIAN HEALTH CARE SYSTEM (1988) (BILLION LIRE)

F I N A N C I N G

	Public	Private	Total
P u b l i c	Public Hospitals, Public Health, Non Hosp. Public Polyclinics and Other Health Services	Prescriptions and Charges on Drugs, Specialist Visits, Diagnostic Tests, Spas	
R O	36,535 46.5%	1,377 1.8%	37,912 48.3%
V I S I O N	Drugs, GPs, Internal and External Contracted Specialist Care, Private Hospitals	Companies Funds Private Health Ins. Private Expenditures	800 582 14,932
	24,286 30.9%	16,314 20.8%	40,600 51.7%
T o t a l	60,821 77.5%	17,691 22.5%	78,512 100%

Source: Census and DoH (Central Service for Health Planning)

by public structures (public hospitals, public outpatient clinics etc.); it represents 46.5% of the total expenditure in health care.

The second quadrant (upper right) shows expenditure directly financed by private citizens for goods and services provided by the NHS (typically prescription charges); it represents only 1.8% of the total expenditure.

The third quadrant (lower left) shows expenditure financed by the NHS for goods and services provided by private bodies (drugs dispensed in pharmacies and contracted out health services contracted out)) 30.9% of total expenditure.

Finally the fourth quadrant (lower right) shows expenditure financed by private citizens for goods and services provided by private bodies (what was referred to earlier as net private expenditure); it represents 22.5% of the total expenditure.

3.3.3 Main Areas of Public Expenditure

Tables 3.5, 3.6, 3.7 and 3.8 show the trends of the main areas of public current expenditure, both crude values and indexed (1984 = 100), according to two different classifications: the "subjective classification" which aggregates expenditure on the grounds of productive factors (for instance, personnel and goods and services); and the "functional classification" which aggregates expenditure on the grounds of health services delivered (for example, primary care, hospital services and prevention).

Before commenting on the tables, it is necessary to point out that the second classification is not in universal use. Only ten Regions require that their LHUs provide it and therefore it is impossible to assess total formal expenditure in public hospitals (which is the most important expenditure in the Italian health care).⁵⁵

(55) The real problem of the functional classification is that it requires the LHUs to have cost accounting for allocating the expenditure to the services; at the moment cost accounting has been implemented in few Italian Regions and in a heterogeneous way.

However, Istat provides expenditure estimates for hospitals, preventive activity and, from 1985, administrative services; the first one is the most significant. Moreover, most of the expenditure on primary care and outpatient specialist care can be identified as they are contracted out.⁵⁶

Table 3.5 shows that **personnel** expenditure has increased more slowly than other items in the period (less than total expenditure), whereas expenditure on **goods and services** directly purchased by the LHUs and on **national health contracts**⁵⁷ has increased more rapidly.

The percentage of the budget accounted by personnel has decreased during the period (from 42.2% in 1984 to 39.1% in 1989), that for goods and services has remained steady (from 17.8% to 18.1%) and that for national health contracts has slightly increased (from 34% to 35.8%) (see Table 3.6).

Table 3.5

**TREND OF PUBLIC CURRENT EXPENDITURE ON HEALTH CARE
(SUBJECTIVE CLASSIFICATION) 1984 = 100**

	1984	1985	1986	1987	1988	1989
Personnel	100.0	107.9	114.7	136.2	154.5	166.3
Goods and Services	100.0	111.0	123.3	139.0	158.7	182.0
National Health Contracts	100.0	117.1	122.9	154.0	177.2	187.9
Total	100.0	112.4	120.3	143.7	165.0	179.2

Source: DoH (Central Service for Planning)

-
- (56) As GPs and contracted specialist care represent the overwhelming share of the expenditure in these areas, they have been included in the tables of the functional classification.
- (57) The national health contracts include private hospitals, GPs, internal and external specialist services and pharmaceuticals (in pharmacy). Expenditure on those contracts is analysed in detail in the following tables.

Table 3.6

PUBLIC CURRENT EXPENDITURE ON HEALTH CARE (SUBJECTIVE CLASSIFICATION) (BILLION LIRE)

	1984		1986		1988		1989	
	Lire	%	Lire	%	Lire	%	Lire	%
Personnel	15,802	42.2	18,122	40.2	24,411	39.5	26,286	39.1
Goods and Services	6,666	17.8	8,222	18.2	10,578	17.1	12,133	18.1
National Health Contracts	12,725	34.0	15,714	34.9	23,054	37.3	24,022	35.8
Other Expenditure	2,281	6.1	3,006	6.7	3,777	6.1	4,731	7.0
Total	37,474	100.1	45,064	100.0	61,820	100.0	67,172	100.0

Source: DoH (Central Service for Health Planning)

It is not clear whether the decreasing percentage of spending on personnel is due solely to the freeze on recruitment since 1983 or if it also reflects the non-inflationary increase of pay during the period (there has been only one renewal of contract during the period analysed, in 1987), since data on NHS personnel during this period are too unreliable to answer this question. However the first factor is likely to be the more important.

More interesting are the data in Tables 3.7 and 3.8, which show the changes in functional expenditure under broad headings.

Table 3.7

**TREND OF PUBLIC CURRENT EXPENDITURE ON HEALTH CARE
(FUNCTIONAL CLASSIFICATION) 1984 = 100**

	1984	1985	1986	1987	1988	1989
Public Hospitals(*)	100.0	111.8	115.4	132.4	149.0	166.8
Contracted Hospitals	100.0	116.8	122.2	148.6	165.0	177.9
Total Hospitals	100.0	112.5	116.3	134.5	151.1	168.3
Drugs in Pharmacy	100.0	127.3	132.7	163.1	186.0	201.5
Internal Specialists	100.0	116.0	120.6	156.9	169.9	184.2
External Specialists	100.0	112.0	113.2	175.4	241.9	214.2
G.P.s	100.0	107.8	109.4	140.9	160.7	160.6
Prevention(*)	100.0	137.7	148.3	175.9	198.1	215.3
Other Health Expenditure	100.0	116.4	139.8	170.0	219.2	265.1
Total	100.0	112.4	120.3	143.7	165.0	179.2

(*) Estimate

Source: Istat and DoH (Central Service for Health Planning)

Table 3.8

PUBLIC CURRENT EXPENDITURE ON HEALTH CARE (FUNCTIONAL CLASSIFICATION) (BILLION LIRE)

	1984		1986		1988		1989	
	Lire	%	Lire	%	Lire	%	Lire	%
Public Hospitals (*)	17,882	47.7	20,640	45.8	26,645	43.1	29,834	44.4
Private Hospitals	2,691	7.2	3,289	7.3	4,439	7.2	4,786	7.1
Total Hospitals	20,573	54.9	23,929	53.1	31,834	50.3	34,620	51.5
Drugs	5,825	15.5	7,730	17.2	10,834	17.5	11,735	17.5
Internal Specialists	399	1.1	481	1.1	678	1.1	735	1.1
External Specialists	1,209	3.2	1,368	3.0	2,924	4.7	2,590	3.9
G.P.s	2,601	6.9	2,846	6.3	4,179	6.8	4,176	6.2
Prevention (*)	1,343	3.6	1,992	4.4	2,660	4.3	2,891	4.3
Other Health Expenditure	900	2.4	1,258	2.8	1,973	3.2	2,386	3.6
Other Expenditure	4,624	12.3	5,460	12.1	7,488	12.1	8,039	12.0
Total	37,474	100.0	45,064	100.0	61,820	100.0	67,172	100.0

(*) Estimate

Source: Istat and DoH (Central Service for Health Planning)

The rate of rise of **GPs, hospital services and internal contracted specialist care** slows in the period. While the proportion of total expenditure spent on internal specialists remains steady (1.1% in both 1984 and 1985), percentages on GPs and hospital services decrease (from 6.9% to 6.2% and from 54.9% to 51.5% respectively).

The proportion of total expenditure on hospital services decreased markedly, but only in public hospitals: in fact the percentage spent on private hospitals remained steady (7.2% in 1984 and 7.1% in 1989).

The increase of expenditure in the period for public hospitals is determined only by the cost per day of stay, because the number of admissions and the mean length of stay diminished significantly⁵⁸. The small increase in the cost per day of stay was predictable because this figure is mainly affected by expenditure in personnel.

For private hospitals, however, the increase in the cost per day of stay affected the trend of total expenditure less because the mean length of stay remained nearly steady and the number of admissions rose⁵⁹.

Some areas showed increases significantly more than the rise in total expenditure: **pharmaceutical care** (from 15.5% of the total expenditure in 1984 to 17.5% in 1989); **external contracted specialist care** (from 3.2% to 3.9%), **preventive care** (from 3.6% to 4.3%) and **other health expenditure** (from 2.4% to 3.6%). The level of net pharmaceutical expenditure rose considerably and regularly, notwithstanding the central policy of limiting price rises to the rate of inflation, of slowing down the updating of NTP and of increasing the cost of prescription charges. The main reasons for the continuing rise in net pharmaceutical expenditure are that all these policies have been thwarted, firstly

(58) This analysis has been done mathematically, using the following formula: $EXP = A \times LoS \times CDoS$ where EXP is the hospital expenditure, A the number of admissions, LoS the mean length of stay (admission/days of stay) and CDoS the cost per day of stay (EXP/days of stay).

(59) For the private hospitals it is impossible to relate the expenditure to the trend of productive factors. In fact the expenditure concerns the income of the private hospitals (the equivalent of the expenditure of the NHS), and not the costs.

by the successful strategies of pharmaceutical companies in pushing "new" more expensive drugs (which often differ from the former in terms of price rather than therapeutical effectiveness) and secondly by patients bypassing "tickets" (with the complicity of GPs), see Section 2.1.2. The volume of items prescribed seems to be steady⁶⁰.

External specialist care dramatically increased in 1987 and 1988 because of the renewal of contracts and the abolition of "tickets" on specialist visits and diagnostic procedures (see Section 2.2.4). However prices had been rarely updated in the previous period (at the beginning of the 1980s the incidence of this expenditure was more than 5%) and the re-introduction of "tickets" in 1989 led to an immediate decrease in expenditure. Expenditure on prevention rose gradually in the period. It should be emphasised that estimates of expenditure on preventive care are difficult to assess because they are significantly influenced by subjective evaluations. However the slow rise in crude values cannot be considered consistent with the aim of the Reform Law, which indicated that this activity be developed as a priority.

Other health expenditure (prostheses, spas, transportation of patients, home care, social services, etc.) is such a heterogeneous category that interpretation is difficult. However it should be noted that this expenditure has increased dramatically; this could be a result of the high local autonomy in determining most of these expenditures.

The conclusion which can be drawn from this analysis is that control of overall expenditure is determined mainly by factors decided centrally, through the freezing of recruitment, delay in renewals of contracts and updating of prices. With the exception of pharmaceutical spending, expenditure in each of these categories shows considerable year to year variation, but the overall trend is a gradual rise.

(60) It is difficult to assess the market in volume because public sources only provide the figures for prescriptions; they consider the total number of items which is steady. In addition to changes in products, it is necessary to note that the size of packages of the same products can change dramatically because companies try to push the largest one.

The most considerable and consistent rates of growth are shown by the outlays for which local autonomy is higher (goods and services, other health expenditures).

Analysis of expenditure suggests therefore a system characterized by inconsistency between the goals of different institutional tiers; each level has its "share of power", but there is not a broad health policy. The decrease in expenditure on hospital services and the increase in expenditure on prevention⁶¹ should be interpreted as a result of this fragmentation, rather than as being consistent with the basic aim of the Reform Law which is to redistribute real resources from diagnostic to preventive activities.

3.3.4 Geographical Distribution of Public Expenditure

Tables 3.9, 3.10 and Graph 3.5 show a geographical analysis of public expenditure, with data broken down into macro areas⁶².

Table 3.9 shows the geographical distribution of total public expenditure on health care. No sizeable change is noted in the period. The percentage of expenditure going to the **southern** area, the poorest one, remained steady (33.9% in 1985 and 1989), while that of the **north-western** area slightly increased (from 25.4% to 26.1%) with a corresponding reduction in the **north-eastern** (from 12.1% to 11.7%) and **central** (from 28.6% to 28.3%) areas. The slight changes in overall expenditure are not sufficient to make any significant change in levels of per capita expenditure.

Table 3.10 is more interesting because it shows the proportions spent on the most important broad headings at regional level⁶³. The amounts spent on personnel and goods and services are higher in the north-eastern area (46.3% and 22.3% of the total in 1989), where public hospital beds are plentiful, because these expenditures are mainly related to

(61) It is important to remember that these figures are estimates calculated by Istat.

(62) With regard to macro areas see Footnote (19) Section 2.1.

(63) These figures are taken from LHU reports, consequently hospital services are not included.

Table 3.9

GEOGRAPHICAL DISTRIBUTION OF PUBLIC CURRENT EXPENDITURE ON HEALTH CARE (BILLION LIRE)

	1985		1987		1988		1989	
	Lire	%	Lire	%	Lire	%	Lire	%
North-West	10,713	25.4	13,779	25.6	15,849	25.6	17,554	26.1
North-East	5,091	12.1	6,456	12.0	7,206	11.7	7,836	11.7
Central	12,041	28.6	15,229	28.3	17,585	28.4	19,008	28.3
South	14,263	33.9	18,400	34.2	21,180	34.3	22,774	33.9
Total	42,108	100.0	53,864	100.0	61,820	100.0	67,172	100.0

Source: DoH (Central Service for Health Planning)

public hospital services; on the other hand, the percentage of total pharmaceutical expenditure is very low (12.8% in 1989).

The reverse situation is seen in the southern area, where the proportion of expenditure on pharmaceuticals is particularly high (21% in 1989), whereas personnel and goods and services percentages are low (36.3% and 14.5% in 1989). These figures indirectly support the view that Italian GPs prescribe **either** drugs or hospital care to their patients, particularly for elderly patients who are not seriously ill (Garattini and Capeccia, 1984). Therefore in southern areas where the density of beds is lower, GPs are more likely to prescribe drug therapy. In fact the consumption of drugs is inversely related to the number of admissions.

The proportion of contracted specialist outpatient care (internal and external) is high in the central area (4.3% in 1989) and particularly in the southern area (7.6% in 1989) because of the high density of private clinics in those regions; the situation is the reverse in the north-eastern area (2.6% in 1989).

The consistent proportion of expenditure going to GPs throughout the country is due to the capitation system.

With regard to per capita public expenditure on health care at local level (Graph 3.5), the north-eastern area, and particularly the central area, have higher values (+3.7% and +9.3% than the national per capita expenditure in 1989), whereas the southern area has the lowest (-7.3%). The only significant changes in the period are the decreasing differences from the national figure of the north-western area (from -4.4% in 1985 to -0.6% in 1989) and the north-eastern area (from +6.4% to +3.7%). However the scattering at the regional level has not decreased⁶⁴ and the percentage gap between the minimum and the maximum regional values is still the same (from -17% to +18.6% in 1985, from -18.5% to 17.9% in 1989).

(64) Coefficient of Variation is the indicator which has been used to measure the variation at the regional level.

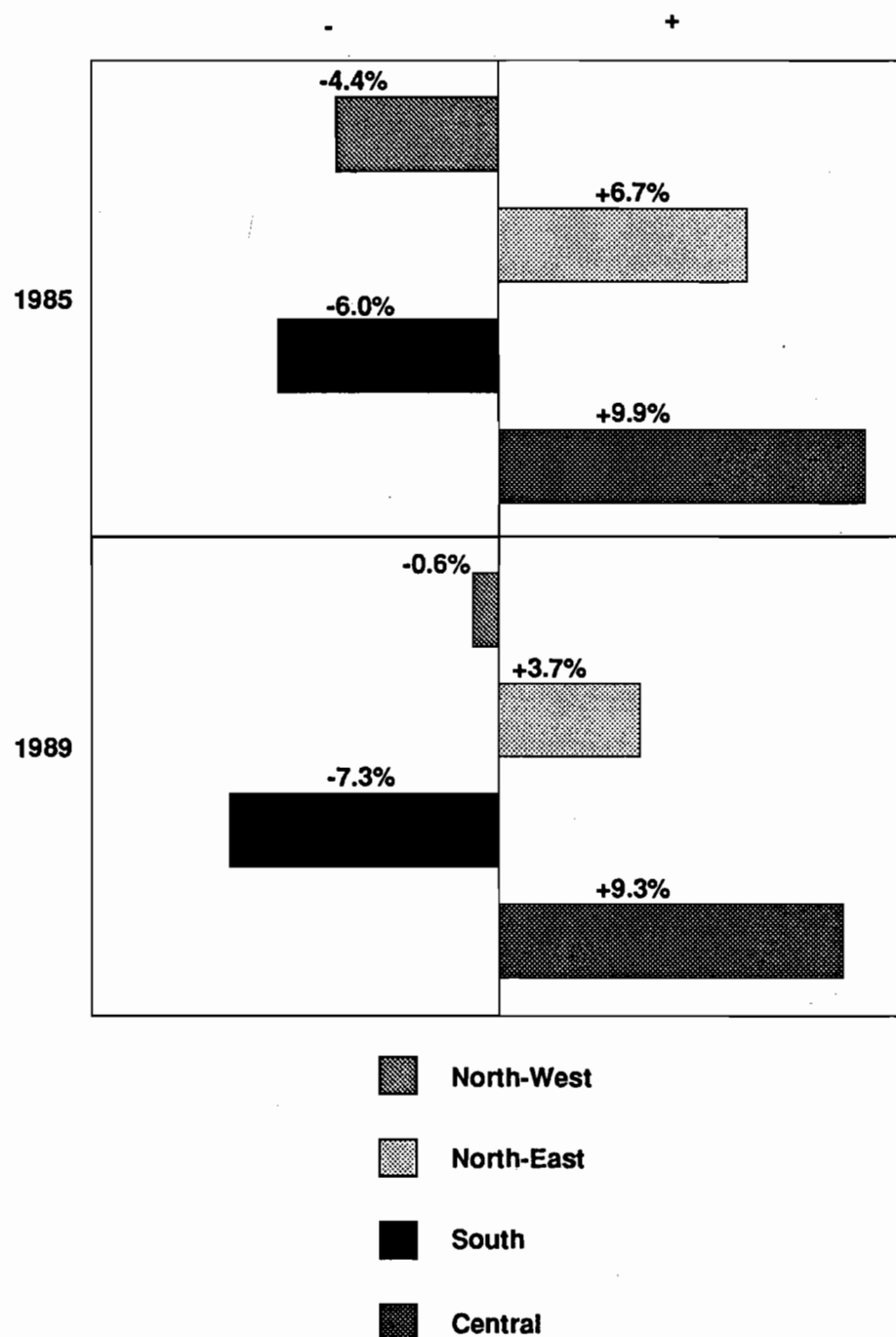
Table 3.10

GEOGRAPHICAL DISTRIBUTION OF BROAD HEADINGS OF PUBLIC CURRENT EXPENDITURE ON HEALTH CARE (1989)

	Personnel %	Goods & Services %	G.P.s %	Drugs %	Contracted Specialists %	Other Health Expenditure %	Other %	Total %
North-West	37.99	20.31	5.84	16.24	3.29	3.82	12.51	100.0
North-East	46.26	22.28	5.68	12.80	2.60	4.06	6.32	100.0
Central	40.64	18.49	5.78	16.30	4.34	3.04	11.41	100.0
South	36.30	14.52	7.06	21.01	7.56	3.60	9.95	100.0
Total	39.13	18.06	6.22	17.47	4.96	3.55	10.61	100.0

Source: DoH (Central Service for Health Planning)

GRAPH 3.5
GEOGRAPHICAL PER CAPITA EXPENDITURES COMPARED
TO NATIONAL FIGURE



Source: DoH (Central Service for Health Planning)

The conclusion which can be drawn from the regional analysis of health care expenditure is that distribution of broad expenditure is fairly well balanced from a financial point of view, even though the regional differences during the period 1985-1989 decrease slightly.

However the distribution of expenditure among the different services is still very varied. In particular, it is necessary to underline that the rise in expenditure in the southern area is mainly related to private hospital services, pharmaceutical spending and external contracted specialist care, which are the most open to abuse (as noted in Section 2). This confirms that geographical financial reequilibrium has not been determined by a positive structural reequilibrium of the services delivered.

4. CONCLUSION

The Italian NHS was introduced in 1978 and has developed slowly. The attempt to allow political participation at all local levels and to concentrate all the services dealing with health care in a single system has produced challenges which have been met with limited success.

Some major difficulties have emerged which call for substantial and structural changes:

1. Institutionally, the system is characterised by the presence at all the local tiers of political party appointees, who enjoy a high degree of autonomy. At the central level, the traditional political weakness of Italian government has prevented the implementation of a clear and consistent health care policy. Consequently, a strong centralised planning policy (like that envisaged by the Reform Project) stands little chance of success and would probably serve to widen the difference between the formal principles and structure of the system and its actual behaviour and performance.
2. Organisationally, the development of managerial skills in the NHS is constrained both by the lack of training schemes and the bureaucratisation induced by the Italian public

administration system. The failure to delineate the boundaries between political and managerial responsibilities has led to difficult relationships between the political appointees who comprise the Management Committees of the LHUs, and the senior management staff who are employed by them.

3. Service delivery has remained as fragmented as ever. The attempt to rationalise the provision of services has been undermined by (i) the success of the medical profession in defending existing interests and (ii) the high level of health care services provided by private sector facilities. This fragmentation creates acute perverse incentives at all levels of service delivery.

4. Allocation of financial resources has been considerably affected by the institutional and political situation. The formal budgetary system has not been properly implemented and as a result political negotiation has maintained a system which benefits those health authorities which purposefully overspend and penalises those which try to work within their budget allocation. As a consequence, the system is characterised by a lack of local control and accountability for expenditure.

5. Expenditure has grown considerably during the last years, but at a lower rate than might be expected given the lack of financial accountability. In international terms, the level of expenditure is still relatively low. It appears that central tools for controlling expenditure (eg number of personnel, pay levels, cost of prescription charges) have successfully constrained overall expenditure. Consequently, the failure of local financial management has not affected total expenditure but is a significant factor in determining the geographical distribution of expenditure and inefficiency in resource allocation.

There are two general changes which might assist in the reduction of the major inefficiencies which thrive in the reformed Italian health care system.

Firstly planning and financing the health system could take account of regional autonomy. Whilst central government retains responsibility for developing broad health policies, regions could become autonomous and be held financially accountable in order

to increase local control of expenditure. Local taxation to finance health care might increase accountability as the Regions would then be directly responsible for deficits.

Secondly, the boundaries between political and managerial roles at local level should be clarified. If Regions assume responsibility for planning and financing local health care provision, it will be necessary to ensure the development of local health service management. The role of politicians and representatives of political parties should be limited to one of advocacy on behalf of the population. The proposals put forward in the Reform Bill Project are designed to meet these objectives. It is, however, uncertain at this stage whether the reforms will be fully implemented.

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USEFUL TRANSLATIONS

ENGLISH	ITALIAN
Administrative Coordinator	Coordinatore Amministrativo
Administrative Manager	Direttore Amministrativo
Board of Directors	Consiglio di Amministrazione
Capital Expenditure	Spesa in Conto Capitale
Chairman of the LHU	Presidente dell'USL
Classified Hospital	Ospedale Classificato
Consultant	Primario
Council of Health Professionals	Consiglio dei Sanitari
Current Expenditure	Spesa Corrente
Department	Dipartimento
Department of Health (DoH)	Ministero della Sanità
Directing Office	Ufficio di Direzione
District	Distretto
General Manager	Direttore Generale
General Practitioner (GP)	Medico di Base
Government Contributions	Fiscalizzazione Oneri Sociali
Gross Domestic Product (GDP)	Prodotto Interno Lordo (PIL)
Health Contributions	Contributi Sanitari
Health Coordinator	Coordinatore Sanitario
Health Manager	Direttore Sanitario
Interregional Health Fund (IHF)	Fondo Sanitario Interregionale (FIRS)
Local Health Unit (LHU)	Unità Sanitaria Locale (USL)

ENGLISH

ITALIAN

Local Income	Entrate Locali
Management Committee	Comitato di Gestione
Medical Guard	Guardia Medica
National Council of Health	Consiglio Sanitario Nazionale
National Health Fund (NHF)	Fondo Sanitario Nazionale (FSN)
National Health Plan (NHP)	Piano Sanitario Nazionale (PSN)
National Health Service (NHS)	Servizio Sanitario Nazionale (SSN)
National Therapeutic Formulary (NTF)	Prontuario Terapeutico Nazionale (PTN)
Outpatient Clinic	Poliambulatorio
Private Hospital	Casa di Cura
Regional Health Fund (RHF)	Fondo Sanitario Regionale (FSR)
Regional Health Plan (RHP)	Piano Sanitario Regionale (PSR)
Registrar	Assistente Ospedaliero
Scientific Institute	Istituto Scientifico
Senior Registrar	Aiuto Ospedaliero
Service	Servizio
Standardized Mortality Ratio (SMR)	Tasso di Mortalità Standardizzato (TMS)
Superior Health Institute	Istituto Superiore di Sanità
Tourist Guard	Guardia Turistica
Ward	Divisione